Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(8727

FILM No. G98 OCT 4 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 11 days
Hospital, institution, or street address where death occurred: Spring Grove State Hospital
How long in hospital or institution? 2 months, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland
County: ~~Baltimore~~
City or town: Baltimore (Catonsville)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1940 W. Lanvale Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Lillian Marie Ahern
3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John T. Ahern
6.(c) If alive, give age: 64 years
7. Birth date of deceased (mo., day, yr.): August 17, 1886

8. AGE: Years	Months	Days	If less than one day
59 ~~58~~	11	27	hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER — 12. Name: Claude Atchison
13. Birthplace: Washington, D. C.
MOTHER — 14. Maiden name: Mary Gormley
15. Birthplace: Washington, D. C.
16. Informant: Hospital records
Address: Catonsville-28, Md.
17. Burial — Date thereof: 9/17/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Baltimore, Md.
18. Funeral director: H. W. Meads and Son
Address: 805 N. Calvert Street
19. Sept 15 1945 — A. W. Uhrich (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 14 1945, at 5:00 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31 1945, to September 14 1945
and that I last saw her alive on September 14 1945

Immediate cause of death	DURATION
Acute Cardiac failure	
Due to: Myocardial degeneration	
Due to: Fractured left femur accident	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident — Date of: Aug 3 45 12-30 PM
Where did injury occur? Catonsville Balto Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Hospital
Means of injury: Pushed down on floor — Injured at work? no

23. SIGNATURE: Geo. M. Kieffer — Dep't Med. Exam. B. Co. — M. D. or other
Address: 1010 Leeds ave — Date signed: Sept 14 45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

68728

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Laurel, RFD

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Clarence Aitcheson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Maggie Miles Aitcheson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 5, 1858

8. AGE:	Years	Months	Days	If less than one day
	87	-	25	..... hrs. ..... min.

9. Birthplace: Prince George County (Town, county, and state)

10. Usual occupation: Blacksmith

11. Industry or business: Blacksmith

FATHER 12. Name: William Aitcheson

FATHER 13. Birthplace: Scotland

MOTHER 14. Maiden name: Anna Caldwell

MOTHER 15. Birthplace: Scotland

16. Informant: Hospital records

Address: Catonsville, Balto. 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-3-45 (month) (day) (year)

Cemetery or crematory: Ivy Hill

Location: Laurel Md.

18. Funeral director: Mc Witt Donaldson

Address: Laurel, Md.

19. 10/2 19 45 (Date rec'd by registrar) W. C. Anderson (Registrar) Equity Local 29

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 30 19 45 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Pulmonary Oedema	
Due to: Cardio vascular disease	
Due to: Fractured Left femur	
Other conditions: accident	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Sept 30 19 45

Where did injury occur? Catonsville (City or town) Baltimore (County) Md. (State)

Injured at home, farm, industry, public place (where?) Hospital

Means of injury: Fall on floor Injured at work? no

23. SIGNATURE: Geo. McCaffrey Geo. McCaffrey M. D. or other

Address: 1010 Leadenhall Date signed: 10-1-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

8729

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County Baltimore
City or town Granite Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 55 years
Hospital, institution, or street address where death occurred:
Davies Ave.,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Granite
(If outside city or town limits, write RURAL and give nearest town)
Street No. Davies Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jacob Edward Albright

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Effie D. Albright
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 19, 1861

8. AGE: Years	Months	Days	If less than one day
84	3	10	..... hrs. ..... min.

9. Birthplace Woodstock Howard Co. Md.
(Town, county, and state)
10. Usual occupation Granite cutter
11. Industry or business
FATHER 12. Name Unknown
13. Birthplace Unknown
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown
16. Informant Mrs. Ezra A. Albright
Address Granite, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 2, 1945 (month) (day) (year)
Cemetery or crematory St. Alphonsus
Location Woodstock, Md.
18. Funeral director Easton Sons
Address Ellicott City, Md.
19. 10/11/1945 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1945, at 4:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Cardiac Failure	
Due to Cardio Vascular Disease	
Due to	
Other conditions Sudden death Inquest	

(Include pregnancy within 3 months of death)
Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Geo. M. Kirby M. D.
M. D. or other
Address 1010 Leadenhall Date signed 10-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-A)

CERTIFICATE OF DEATH

68730

Reg. Dist. No. 35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore.

City or town: Rural near White Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore.

City or town: Rural near White Hall.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Village of Shane.

(If rurel, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Webster McClung Anderson.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Ruth Hershner

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): December 16, 1899.

8. AGE: Years	Months	Days	If less than one day
45	9	7	...hrs. ...min.

9. Birthplace: White Hall, Md. R.D. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Own Farm.

FATHER — 12. Name: E. Milton Anderson

FATHER — 13. Birthplace: White Hall, Md. R.D.

MOTHER — 14. Maiden name: Laura McClung

MOTHER — 15. Birthplace: Norrisville, Md.

16. Informant: Mrs. Ruth H. Anderson.

Address: White Hall, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof September 26 1945 (month) (day) (year)

Cemetery or crematory: West Liberty

Location: White Hall, Balto. Co., Md.

18. Funeral director: Jacob Hartenstein

Address: New Freedom, Pa.

19. Sept 24 1945 (Date rec'd by registrar) Christy J. Butler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 23, 1945, at 8:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1936, to Sept. 23 1945

and that I last saw him alive on Sept 22 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	3 hrs.
Due to	
Due to	
Other conditions: Chronic nephritis, Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: G. M. France M. D. or other

Address: Parkton, Md. Date signed 9/25/45 K.J.

C8731 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

Reg. Dist. No. 30

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs, 1 mo 9 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 2 years 1 mo 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1637 Wilkens Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Elizabeth Appleby

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Wm. C Hutchinson-Appleby

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 14 1876

8. AGE:

Years	Months	Days	If less than one day
68	8	19	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER

12. Name: Thomas Kilbee

13. Birthplace: Ireland

MOTHER

14. Maiden name: Elizabeth Daly

15. Birthplace: Baltimore Md

16. Informant: Hospital Records

Address: Catonsville 28, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-5-45 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: 3700 old Frederick Rd

18. Funeral director: Harry A Weitzel

Address: 4101 Edmondson Ave

19. Sept. 3 1945 (Date rec'd by registrar) A. W. Kedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 2 1945 at 8:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1943, to Sept 2 1945 and that I last saw h. alive on Sept 2 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	1 wk
Due to: Hypertensive Cardio-Vascular disease	Indef.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Howe C. Mead M.D. M. D. or other

Address: Catonsville 28 Md Date signed 9/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-C

CERTIFICATE OF DEATH

08732

Reg. Dist. No. 4 1

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 149 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 149 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Kingsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. Kingsville, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: SAW

3.(a) FULL NAME

TRUEMAN BABYLON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

B.(b) Name of husband or wife: Widowed

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 5-29-77

8. AGE:	Years	Months	Days	If less than one day
	68	4		..... hrs. ..... min.

9. Birthplace: Westminister, Md.
(Town, county, and state)

10. Usual occupation: Retired Painter

11. Industry or business

FATHER 12. Name: Alfred Babylon

13. Birthplace: Maryland

MOTHER 14. Maiden name: Ida Haifley

15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Fac.

Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 1-45 (month) (day) (year)

Cemetery or crematory: Westminster

Location: Carroll Co

18. Funeral director: H Bankard. Sons

Address: Westminster Md.

19. 9/29/45 JS [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 29, 1945, 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3, 1945 19.. to Sept. 29, 1945 and that I last saw him alive on Sept. 29, 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	2 Yrs.
Due to	
Due to	
Other conditions: Right Hemiplegia	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: A.M. Balter 1st M

A.M. BALTER, LT. COL., M.C.M. CLIN. DIR.

Address: Fort Howard, Md. Date signed 9-29-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 18733 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 42 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland
How long in hospital or institution? 42 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Queen Ann
City or town: Centerville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: WILLIAM BAILEY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Bertie Ann Bailey
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): 12-23-92

8. AGE: Years	Months	Days	If less than one day
52	8	18	hrs. min.

9. Birthplace: Queen Ann County, Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: Sandy Bailey
13. Birthplace: Virginia
MOTHER 14. Maiden name: Henrietta Corney
15. Birthplace: Maryland
16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Ft. Howard, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-14-45 (month) (day) (year)
Cemetery or crematory: Centerville
Location: Centerville, Md.
18. Funeral director: Charles R. Law
Address: 802 Madison Ave.
19. 9-12 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-11-45 19... at 9:55 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31, 1945 to September 11, 1945 and that I last saw him alive on September 11, 1945 19...

Immediate cause of death	DURATION
Tuberculosis, chr. pul. far. adv.	6 Mos.
	plus
Due to	
Due to	
Other conditions Absence acquired right eye, G.S.W. Anemia secondary.	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work? MM

23. SIGNATURE: H.Y. Richards
H.Y. RICHARDS, MAJOR, M.C. ACTG.LIN.DIR.
Address: Ft. Howard, Maryland Date signed 9-11-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

18736

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:
County Baltimore Co
City or town Raspeburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Life
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town Raspeburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 11 Greenwood ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Anthony S. Balles

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife Julia Balles
6.(c) If alive, give age 56 years
7. Birth date of deceased (mo., day, yr.) Oct 4th 1885

8. AGE: Years	Months	Days	If less than one day
59			hrs. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual occupation Meat Cutter
11. Industry or business
FATHER 12. Name Joseph Balles
13. Birthplace Germany
MOTHER 14. Maiden name Katharine Mitzel
15. Birthplace Germany
16. Informant Julia Balles
Address 11 Greenwood ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 7/45 (month) (day) (year)
Cemetery or crematory London Park Cem
Location Catty
18. Funeral director Ellicott Funeral Home
Address 200 E Pleasant St
19. Sept 7 19 45 A W Ellicott Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5th 19 45 at 7 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22 19 45 to Sept 5 19 45 and that I last saw him alive on Sept 2nd 19 45

Immediate cause of death	DURATION
Pulmonary Thrombosis	
Due to Old ulceration Stomach	
Obstruction Gastric Emptying	
Due to Neoplasm & scar tissue Duodenal end Stomach	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please nuderline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. V. Clift MD M. D. or other
Address 5010 Greenleaf Road Date signed 9-6-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 18735 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Victory Villa
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 7 Bank Court
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County: Columbia
City or town: Bloomsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles A. Barber

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 30, 1870

8. AGE: Years	Months	Days	If less than one day
75		5	hrs. min.

9. Birthplace: Pa.
(Town, county, and state)
10. Usual occupation: Retired farmer
11. Industry or business
FATHER 12. Name
13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
15. Birthplace
16. Informant: Mr. David F. Barber
Address: Northumberland Pa.
17. Removal (Burial, cremation, or removal. Which?) Date thereof 9/16/45 (month) (day) (year)
Cemetery or crematory: Bloomsburg Pa.
Location
18. Funeral director: Wm. J. Tickner & Sons
Address: North & Pa. Aves.
19. Sept 16 1945 John J. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 15 1945, at 11:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10th 1945 to Sept. 15 1945
and that I last saw h[illegible] alive on Sept. 15 1945

Immediate cause of death	DURATION
Hypertensive Cardio Vascular-Renal Disease	2 yrs
Due to	
Due to	
Other conditions Cerebral Hemorrhage	5 days

(Include pregnancy within 3 months of death)

Major findings of operations: no
Date of op.
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James F. White, M.D.
M. D. or other
Address: 760 E. Eutaw St. Date signed 9/16/45
Baltimore 20, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

68736 (M) 84

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Rosedale - Balto - 21
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balt.
City or town Cedar Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route 13 Box 336 B. Balto 21
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Naomi Leigh Barnes, (f)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife Gabriel Eldridge Barnes
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 11 - 1898

8. AGE: Years	Months	Days	If less than one day
47	1	11	..... hrs. ..... min.

9. Birthplace Winston Salem, N.C.
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business

FATHER
12. Name Wm. R. Riley
13. Birthplace N.C.

MOTHER
14. Maiden name Martha Miller
15. Birthplace N.C.

16. Informant Mr. Gabriel Barnes
Address Cedar Beach, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 24-45 (month) (day) (year)
Cemetery or crematory Zion Lutheran Cem.
Location Golden Ring, Md.

18. Funeral director John G. Connelly
Address 418 Eastern Ave. Essex

19. Sept. 24 19 45 John G. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 19 45, at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Coronary Occlusion	1 hr.
Due to Hypertension C.V.D.	4 yrs.
Due to Diabetes Mellitus	4 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE M. D. Davis M.D.
Asst. Phy. Mt. Vernon - Balto M. D. or other
Address Dundalk - Md. Date signed 9-26-45

#for Birth punched card: (14768)

Birth & Death

08737 P

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILLBIRTH~~

Reg. Dist. No.....

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. **PLACE OF BIRTH:**
   County Balto.
   City or town Balto 27 Md
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution: 5204 Carroll Place
   Length of mother's stay in County 6 yrs
   (How many years, or months, or days. SPECIFY WHICH)

2. **USUAL RESIDENCE OF MOTHER:**
   State Maryland 5204 Carroll Place
   County Baltimore
   City or town Balto 27 Md
   (If outside city or town limits, write RURAL and give nearest town)
   Street No. 5204 Carroll Place
   (If RURAL give LOCATION)

3. Name of child Newborn
4. Date of birth Sept 1 1945 Hour 1005 A.M.
5. Sex F | 6. Twin or triplet —
7. No. of weeks pregnancy 34 wks.

FATHER OF CHILD

8. Full name Edward Charles Batz
9. Color W 10. Age at time of this birth 29 yrs.
11. Usual occupation U. S. Navy

MOTHER OF CHILD

12. Full maiden name Audrey Frances Myers
13. Color W 14. Age at time of this birth 24 yrs.
15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 3
    (b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead? 0

17. Did child die before labor? No During labor? No
18. Pregnancy, complications of None
19. Labor: (a) Complications of None
    (b) Induced? No
20. (a) Was there an operation for delivery? No (Yes or No)
    (b) State all operations, if any —
    (c) Did child die before operation? —
    During operation? —

21. **Cause of stillbirth.** Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
    (a) Fetal causes Atelectasis — Mucous in Trachea
    (b) Maternal causes None PREMATURITY

22. I certify to the birth of this child who was born ~~dead~~ ALIVE on the date and hour above stated.
    Signature J. Earl Pass M.D.
    (Specify if M. D., midwife, or other)
    Address 4001 Wilkens Ave

23. (a) Burial (b) Date thereof Sept. 3/45
    (Burial, cremation or removal) (month) (day) (year)
    (c) Cemetery or crematory Mt. Olivet
24. (a) Funeral director Harry H. Whittle
    (b) Address 401 Edmondson Ave

25. (a)..... (b).....
    (Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
    .....Health Officer, per.....

* See Instruction C on stub.

Child LIVED 4½ hours

Tab. as live birth

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C8738 P

Reg. Diat. No. 38

1. PLACE OF DEATH:
County Baltimore
City or town Towson, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Eudowood Sanatorium Towson 4, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Balto. City.
City or town Balto.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 50 W. Biddle St
(If rural, give LOCATION)
2.(a) If veteran, name war V

3.(a) FULL NAME Vernon Beard.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Infant

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 17, 1943

8. AGE: Years	Months	Days	If less than one day
2	2		..... hrs. ..... min.

9. Birthplace Balto. Maryland. (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Vernon Beard.
13. Birthplace Maryland.

MOTHER
14. Maiden name Ruth Snyder
15. Birthplace Maryland.

16. Informant Personal History-Hospital Records
Address Eudowood Sanatorium, Towson, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept 15 45 (month) (day) (year)
Cemetery or crematory Hancock Md
Location Hancock
18. Funeral director Wiesman Cook Inc
Address 1217 St Paul Street

19. Sept. 14 1945 (Date rec'd by registrar) A. W. Hebeler A.E.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1945 at 12:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13, 1945 to Sept 14 1945 and that I last saw him alive on September 14 1945

Immediate cause of death	DURATION
Pulmonary Tb.	Nov. 1944.
Due to	
Due to	
Other conditions Tuberculous meningitis	

(Incinde pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. H. Finkelstein M.D. M. D. or other
Address Towson, Maryland Date signed 9-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

68739

Reg. Diat. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Balto

City or town: Ventnor Villa

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: N. C. County: Davidson

City or town: Thomasville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Martha E Beck

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: James C.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 9/8/84

8. AGE: Years: 61 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: N. C. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER — 12. Name: Alex Curry

13. Birthplace: Davidson Co. N.C.

MOTHER — 14. Maiden name: Mary E. Sowers

15. Birthplace: Davidson Co. N.C.

16. Informant: Raymond T. Beck

Address: 16 Yawmeter Drive

17. [illegible] Date thereof: 10-2-45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Shallow Cemetery

Location: Davidson Co. N C

16. Funeral director: James J Buzdygnisky

Address: 407 Eastern Ave Rd. Easy

19. Sept 29 1945 (Date rec'd by registrar) John H. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 28 1945 at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 26 1945 to Sept 28 1945 and that I last saw h[illegible] alive on Sept 28 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Essential Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: P.R. Estep M.D. M. D. or other

Address: 2 Fenway S. Balto 21 Date signed: 9-28-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

8740

Reg. Diat. No. 40

1. PLACE OF DEATH:

County Baltimore

City or town Notch Cliff near Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Notch Cliff near Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Sister Mary Emanuela Beckler

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 9, 1862

8. AGE: Years	Months	Days	If less than one day
83	1	5	..... hrs. ..... min.

9. Birthplace Philadelphia Pa.
(Town, county, and state)

10. Usual occupation Teacher

11. Industry or business

FATHER

12. Name Louis Beckler

13. Birthplace Alsace Germany

MOTHER

14. Maiden name Catherine Hertlein

15. Birthplace Wurtemberg, Germany

16. Informant Sr. Mary Clara

Address Notch Cliff, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 26/45 (month) (day) (year)

Cemetery or crematory Notch Cliff

Location Green Acres

18. Funeral director Geo. M. Fritz Son

Address 811 N Wolfe St

19. Sept 25 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 19 45 at 12.10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 44, to Sept. 24 19 45

and that I last saw h.. alive on July 11 19 45

Immediate cause of death	DURATION
Coronary occlusion	Sudden
Due to	
Due to	
Other conditions Arteriosclerosis and Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. or other

Address Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

08747 44

Reg. Dist. No.

1. PLACE OF DEATH:

County: Balto Co.

City or town: Ft Howard Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto

City or town: Todds Farm. Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

Street No.: AVE B.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Isabelle Beery

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	W.

6.(b) Name of husband or wife: Theodore F.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 17-1885

8. AGE:	Years	Months	Days	If less than one day
	70	6	13	..... hrs. ..... min.

9. Birthplace: Scotland (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: Andrew Paul

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Mary Wasmuth

MOTHER — 15. Birthplace: Scotland

16. Informant: Mrs May Barnett

Address: Todds Farm

17. Transit (Burial, cremation, or removal. Which?) Date thereof 9/3/45 (month) (day) (year)

Cemetery or crematory: Bonaventure Cem

Location: Savannah Georgia

18. Funeral director: Wm Cook Inc

Address: 217 St Paul St

19. Sept 2 1945 (Date received by registrar) Dawson L. Harbor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 2 1945 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2 1945 to Sept 2 1945 and that I last saw h.. alive on Sept 2 1945

Immediate cause of death	DURATION
Coronary occlusion	2 hrs
Due to: Hypertension Cardiac Vascular Lues	1 yr
Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Dawson L. Harbor M. D. or other

Address: Harris Point Date signed 9/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8742

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs 4 mo 29 da
Hospital, institution, or street address where death occurred:
Rosewood State Training School
How long in hospital or institution? 8 yrs 4 mo 29 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3026 Darby St
(If rural, give LOCATION)
2.(a) If veteran, name war: N

3. (a) FULL NAME: Doris Marie Benson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb 19, 1924

8. AGE: Years	Months	Days	If less than one day
21	6	21	..... hrs. ..... min.

9. Birthplace: Baltimore, Md
(Town, county, and state)
10. Usual occupation: Inmate; Rosewood State
11. Industry or business: Training School
FATHER 12. Name: Edgar Benson
13. Birthplace: Baltimore, Md
MOTHER 14. Maiden name: Margaret Garner
15. Birthplace: Baltimore, Md
16. Informant: Institution Records; Rosewood
Address: State Training School; Owings Mills
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/12/45 (month) (day) (year)
Cemetery or crematory: London Park
Location: Baltimore Md
18. Funeral director: Wilson Cook Inc
Address: 1217 E Fort Ave
19. 9/10 1945 (Date rec'd by registrar) A. D. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 9 1945 at 9:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 1943 to Sept 9 1945 and that I last saw her alive on Sept 9 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Unknown
Due to	
Due to	
Other conditions: Epileptic Idiot	Congen
Little's Disease	Congen

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op. none
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: George C Melairy M. D.
M. D. or other
Address: Owings Mills, Md Date signed: 9/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

CERTIFICATE OF DEATH

P

68743

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 days
Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 708 Beaumont Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME
E. Emma Benson

3.(b) Social Security Number
no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife: none
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 24, 1863

8. AGE:	Years	Months	Days	If less than one day
	82	4	5	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: none
11. Industry or business: none

FATHER
12. Name: Joshua L. Benson
13. Birthplace: Mayland

MOTHER
14. Maiden name: Rachel J. Miller
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/2/45 (month) (day) (year)
Cemetery or crematory: Mt. Carmel M. E. Church
Location: Balto. Co. Md.
18. Funeral director: William Cook Inc.
Address: 1217 St. Paul St.

19. Oct 1 19 45 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 29 19 45 at 5:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 31 19 45, to September 29 19 45 and that I last saw her alive on September 29 19 45.

Immediate cause of death	DURATION
Terminal bronchopneumonia	2 hrs
Due to Myocard. insufficiency	Indef
Due to Coronary Sclerosis	"
complicated by hypostasis	"
Other conditions Canc. Lead Disease	"
Metastases	"

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robert E. Gardner M. D. or other
Address: Catonsville 28, Md. Date signed 9/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

08744

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Waldorf,

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: John Walter Berry

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: none

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 22, 1862

8. AGE: Years	Months	Days	If less than one day
83	3	1	..... hrs. ..... min.

9. Birthplace: Charles County, Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER — 12. Name: William L. Berry

FATHER — 13. Birthplace: Charles County, Md.

MOTHER — 14. Maiden name: Margaret Elizabeth Turner

MOTHER — 15. Birthplace: Charles County, Md.

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 9-24-45 (month) (day) (year)

Cemetery or crematory: St. Pauls Cemetery

Location: Waldorf Md.

18. Funeral director: Haydt & Ryan

Address: Waldorf Md

19. 9/24/45 (Date rec'd by registrar) W. C. Andrews Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 23 1945, at 7:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 24 1945, to September 23 1945 and that I last saw h... im ...alive on September 23 1945

Immediate cause of death	DURATION
Broncho pneumonia	1 day
Due to: Arteriosclerotic cardio-renal-vascular disease	Indef.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert E. Gardner M. D.

Robert E. Gardner, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 9/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

8745

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 days

Hospital, Institution, or street address where death occurred:

Haarlem Lodge

How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Newburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME John M. Blunt

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): MAY 30, 1908

8. AGE:

Years	Months	Days	If less than one day
37	3	29	hrs. min.

9. Birthplace: Charles Co. — Md.

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: William L. Blunt

13. Birthplace: District of Columbia

MOTHER

14. Maiden name: Eliza Matthews

15. Birthplace: Maryland

16. Informant: Harlem Lodge Records.

Address: Catonsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 2-45 (month) (day) (year)

Cemetery or crematory: Mt. Rest

Location: La Plata Md

18. Funeral director: Hunt & Ryon

Address: Waldorf Md

19. 10/1 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 29 19 45 at 2:05 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 14 19 45 to September 29 19 45 and that I last saw h. (w.) alive on September 29 19 45

Immediate cause of death	DURATION
Pneumonia — Hypostatic	24 hrs.
Due to: Hemorrhage — cerebral	
meningeal — small	4 days
Due to: Epilepsy — Traumatic	21 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arthur T. McClelland M.D.

M. D. or other

Address: Haarlem Lodge Catonsville, Md. Date signed: 9-29-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

68746 P

Reg. Dist. No. 41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Balto

City or town: Colegate

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital, Institution, or~~ street address where death occurred: 8138 Gough st.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Colgate

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 8138 Gough St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ransom Bowen

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband ~~or wife~~: Alice Emma Bowen

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 28th 1880

8. AGE: Years	Months	Days	If less than one day
64	10	27	..... hrs. ..... min.

9. Birthplace: Island Pond Vt. (Town, county, and state)

10. Usual occupation: Mill Wright

11. Industry or business: Unknown

FATHER — 12. Name: " Bowen

FATHER — 13. Birthplace: "

MOTHER — 14. Maiden name: "

MOTHER — 15. Birthplace: "

16. Informant: Reginald F. Bowen

Address: 8138 Gough st. - Colgate, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/27/45 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Catonsville Md

18. Funeral director: Wilhelm & Son Inc

Address: 1217 E Fort Ave

19. 9/26 45 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 25 1945 at 7a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1945 to Sept 24 1945 and that I last saw him alive on Sept. 24 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 weeks
Due to: Hypertension Cardio Vascular Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: M. A. Jacob M. D. or other

Address: 607 North Pk Rd Date signed 9/25/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

(8747

CERTIFICATE OF DEATH

Reg. Dist. No. 41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto - 22.
City or town: Dundalk.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 yrs.
Hospital, institution, or street address where death occurred: 2702 North Point Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Route 1.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none.

3.(a) FULL NAME ISAAC LINN BOWMAN.

3.(b) Social Security Number none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	divorced.

6.(b) Name of husband or wife: Mary E (Bowman).
Maid. 6.(c) If alive, give age: 63 years
7. Birth date of deceased (mo., day, yr.): Sept 23. 1881.

8. AGE: Years	Months	Days	If less than one day
63	11	27.	...hrs. ...min.

9. Birthplace: Reisterstown - Md.
(Town, county, and state)
10. Usual occupation: Manufacturer.
11. Industry or business: Concrete Block.
FATHER 12. Name: John Bowman.
13. Birthplace: Virginia.
MOTHER 14. Maiden name: Margaret Hannah
15. Birthplace: Reisterstown. Md.
16. Informant: Gladys M. Godown.
Address: 2702 N. Pt. Rd. Balto 22
17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 9/24/45 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Balto. Md.
18. Funeral director: William Cook Inc.
Address: 1217 St. Paul st.
19. 9/27 19 45 (Date rec'd by registrar) are to be issued ghe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 20, 19 45, at 11:33 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January, 19 1940, to Sept. 20, 19 45
and that I last saw h. alive on Sept. 26. 19 45

Immediate cause of death	DURATION
Pulmonary oedema.	1 day.
Due to: Myocardial failure.	1 day
and Cerebral Apoplexy.	9 mo
Due to: Hypertensive Cardio Vascular.	
Other conditions: disease.	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Louis D. Tollin. M.D.
Address: Sparrows Point M. D. or other
Date signed: Sept. 20. Balto-19-Md. 1945

Reid 9/xx
V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

68748 P

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Masonic Home

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Albert Stunkle Burch

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ida M. Anderson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 23, 1872

8. AGE:	Years	Months	Days	If less than one day
	73	7	20	hrs. min.

9. Birthplace: Frederick County, Md. (Town, county, and atate)

10. Usual occupation: Yard clerk

11. Industry or business: Railroad

FATHER — 12. Name: James D. Burch

FATHER — 13. Birthplace: West Virginia?

MOTHER — 14. Maiden name: Clara H.

MOTHER — 15. Birthplace: West Virginia?

16. Informant: Hospital records

Address: Catonsville-28, Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 15-45 (month) (day) (year)

Cemetery or crematory: Meadow Branch

Location: Westminster Md

16. Funeral director: Geo. L. Beyer Jr

Address: 512 Hollins St

19. 9/13 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 12 1945 at 12:10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 7 19 45, to September 12 1945 and that I last saw him alive on September 12 1945

Immediate cause of death	DURATION
Pulmonary oedema	1 day
Due to: Uremia	2 days
Due to: Chronic interstitial nephritis	Indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D. M. D. or other

Address: Balto.-28, Md. Date signed: 9/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

Reg. Diat. No. 18743/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Long Green (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, Institution, or street address where death occurred: Long Green Rd. & Manor Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Long Green (If outside city or town limits, write RURAL and give nearest town)
Street No. Long Green Rd. & Manor Rd. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JOHN F. BURK, SR.

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Marie Ely Burk
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 27th, 1876

8. AGE: Years	Months	Days	If less than one day
69	6	16	hrs. min.

9. Birthplace: Balto. Co., Md. (Town, county, and state)
10. Usual occupation: Storekeeper
11. Industry or business

FATHER
12. Name: John C. Burk
13. Birthplace: Germany

MOTHER
14. Maiden name: Luide Homan
15. Birthplace: Pa.

16. Informant: Mrs. John F. Burk, Sr.
Address: Long Green, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 1945 (month) (day) (year)
Cemetery or crematory: St. Johns Lutheran
Location: Sweetair, Md.

18. Funeral director: Loveless Funeral Home
Address: 7401 Belair Road

19. 9-14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 13th, 1945 at 7:15A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1 1939 to Sept. 13 1945 and that I last saw h[illegible] alive on Sept 13 1945

Immediate cause of death	DURATION
Coronary Thrombosis	6 hrs.
Due to Angina Pectoris	7 Mos.
Due to Hypertensive Sclerotic Cardiovascular Disease	20 yrs.
Other conditions: Nephrectomy (L) for "tumor" at age 28	

(Includn pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Clifford F. Hudson, M.D.
M. D. or other
Address: Bark, Md. Date signed: 9/13/45

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-E)

CERTIFICATE OF DEATH

P 8750 KK

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, Institution, or street address where death occurred:
Vets.Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore
(If ontside city or town limits, write RURAL and give nearest town)

Street No. 1224 Stricker St.
(If rnral, give LOCATION)

2.(a) If veteran, name war WW-I

3. (a) FULL NAME

RICHARD BURR

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	negro	Married

8.(b) Name of husband or wife Mrs. Ada Burr

6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) July 16, 1890

8. AGE:	Years	Months	Days	If less than one day
	55	1	16	..... hrs. ..... min.

8. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name William Burr

13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden name Laura ?

15. Birthplace Baltimore, Maryland

16. Informant Clinical Records, Vets. Adm. Fac.

Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-7-45 (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location 5501 Frederick Ave. Balto.Md.

18. Funeral director Thomas E. Kelson

Address 1303 Pressman St. Balto.Md.

19. 9/4 1945 (Date rec'd by registrar) H. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1945 at 8:55 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 22 1945 to Sept. 2 1945 and that I last saw him alive on Sept. 2 1945

	DURATION
Immediate cause of death: Bronchogenic Carcinoma, right lung	
with associated atelectasis	unknown
Due to:	
Due to:	
Other conditions: Psychosis with Cerebral Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results Bronchogenic Carcinoma

PHYSICIAN: Please nnderline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. T. Brackin Jr.
J.T.BRACKIN, JR. CAPT. M.C.
M. D. or other

Address Veterans Administration Ft. Howard, Md. Date signed 9-2-45

M C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08751

Reg. Dist. No. 31

1. PLACE OF DEATH:

County: Balto

City or town: Granite
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Granite
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Cecelia Butler

3.(b) Social Security Number

4. Sex: F

5. Color or race: Col

6.(a) Single, married, widowed, or divorced: S

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): April 9. 45.

8. AGE: Years — Months 5 Days 1 If less than one day ... hrs. ... min.

9. Birthplace: Balto Co Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Lewis Butler

13. Birthplace: St Marys Co.

MOTHER 14. Maiden name: Margaret White

15. Birthplace: Balto Co Md

16. Informant: Lewis Butler

Address: Granite Md

17. Burial
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: St Alphonsus

Location: Granite Md

18. Funeral director: Lewis Butler

Address: Granite Md

19. 9/10/ 1945 Wm. E. Martin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1945 at 3-20a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...

and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Malnutrition	
Due to: Diarrhea	
Due to	
Other conditions: Sudden death, Inquiry	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE G. H. Schieffer, Deputy Exam Balto Co, M.D. or other

Address: 1010 Leeds av Date signed Sept 10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 24

68752

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Balto
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs
Hospital, institution, or street address where death occurred: Mercy Hospital
How long in hospital or institution? 7 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Anna H Carmody

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr 22 1869

8. AGE: Years 76 | Months | Days 26 | If less than one day: hrs. min.

9. Birthplace: Illinois (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Cornelius Carmody
13. Birthplace: Ireland

MOTHER
14. Maiden name: Anne Cannole
15. Birthplace: Ireland

16. Informant: Margaret McMahon
Address: 3206 16th St Wash DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-19-45 (month) (day) (year)
Cemetery or crematory: St Johns Cem
Location: Catonsville Md

18. Funeral director: Joyce & Farley
Address: Catonsville Md

19. 9/19 19 45 (Date rec'd by registrar) H. C. Lockhart Registrar
Deputy Local Reg. Address: Catonsville 28 Md

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 18 1945 at 7:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 1945, to Sept 18 1945
and that I last saw her alive on Sept 18 1945

Immediate cause of death	DURATION
Pulmonary Thrombosis	9
Due to Stroke	7
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Howard M Smith M. D. or other
Address: Catonsville 28 Md Date signed: 9/19/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

68753 P

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, Institution, or street address where death occurred: US Veterans Facility
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 1623 E Fairvale St (If rural, give LOCATION)
2.(a) If veteran, name war W. W. I. + II

3.(a) FULL NAME Gladys Cavender (GLADYS CAVENDER)

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1885

8. AGE: Years 60 | Months 1 | Days 5 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Nurse U.S. Army

11. Industry or business Retired

FATHER 12. Name Cecil Cavender

13. Birthplace Maryland

MOTHER 14. Maiden name Hannah Ellsworth Slaughter

15. Birthplace Maryland

16. Informant Clinford Reed

Address Veterans Facility Fort Howard

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 19. 1945 (month) (day) (year)

Cemetery or crematory Loudon Park Cemetery

Location Baltimore Md.

18. Funeral director HENRY SANDER & SONS, INC.

Address North Ave. & Broadway

19. 9/18 19 45 A.W. Hedrick Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 19 45 at 9 40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 11 19 45 to Sept 16 19 45 and that I last saw h alive on Sept 16 19 45

	DURATION
Immediate cause of death Coronary occlusion	Sudden
Due to Heart disease Coronary atherosclerosis	6 months
Due to	
Other conditions Pneumonia Lobular	5 days

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hyl Richards MD M. D. or other

Address Fort Howard Date signed Sept 17 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

68754

★ Reg. Dist. No. 43

1. PLACE OF DEATH:

County: Baltimore

City or town: Raspeburg

(If outside city or town limits, write RURAL and give nearest town)

How long in abnve place of death?

Hospital, Institution, or street address where death occurred:

107 Kolb Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Raspeburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 107 Kolb Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

VIVIAN CLIFT

3.(b) Social Security Number

***

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Wm. V. Clift

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 1st, 1876

8. AGE: Years	Months	Days	If less than one day
69	8	0	..... hrs. ..... min.

9. Birthplace: Balto. Co., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Philip J. Young

13. Birthplace: Ohio

MOTHER

14. Maiden name: Sarah A. Rutter

15. Birthplace: Maryland

16. Informant: Mr. Wm. V. Clift

Address: 107 Kolb Ave.

17. burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 4, 1945 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Baltimore, Md.

18. Funeral director: Lasonby Funeral Home

Address: 7401 Belair Road

19. Sept. 1 1945 (Date rec'd by registrar) Mrs. A. L. Reisinger, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 1st, 1945 at 6:15A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1943 to Sept 1 1945

and that I last saw h... alive on Sept 1 1945

Immediate cause of death	DURATION
Coronary Thrombosis	20 mins
Arteriosclerotic cardiovascular	Mard 1943
Due to: renal disease with hypertension	March 1943
Diabetes Mellitus	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M.D.

M. D. or other

Address: 621 Pittsford Rd Date signed: 9/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-6)

CERTIFICATE OF DEATH

08755

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr 1 5 days
Hospital, Institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? 1 mo 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: —
City or town: Balto
(If outside city or town limits, write RURAL and give nearest town)
Street No. 807 Harlan Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Richard Coarts

3.(b) Social Security Number: 219 01 6489

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Christine Coart
6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): February 18th 1900

8. AGE: Years: 45 Months: 7 Days: 1 If less than one day: ... hrs. ... min.

9. Birthplace: Balto Md (Town, county, and state)

10. Usual occupation: Cat Driver

11. Industry or business:

FATHER
12. Name: John Coarts
13. Birthplace: Balto Md

MOTHER
14. Maiden name: Jane
15. Birthplace: Balto Md

16. Informant: Personal History Hospital Records
Address: Eudowood Sanatorium, Towson 4 Md.

17. Burial, cremation, or removal. Which? Burial Date thereof 9/22/45 (month) (day) (year)
Cemetery or crematory: Mt Olivet Cemetery
Location: 2930 Pulaski Hwy.

18. Funeral director: John J Gowan & Son
Address: 901-03 E Collins Street

19. Sept 21 1945 (Date rec'd by registrar) A W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 19 1945 at 1:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 4 1945, to Sept 19 1945
and that I last saw him alive on Sept 18 1945

Immediate cause of death	DURATION
Pulmonary T.B.	
Due to	About 11 Months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: William C Bridges M. D. or other
Address: Towson 4, Maryland Date signed: 9-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for addition of birth date of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

FILM No G98 OCT 4 1945

8756

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs.
Hospital, institution, or street address where death occurred: Spring Grove State Hospital
How long in hospital or institution? 10 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 2220 Lyndhurst Ave (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Herbert Cohen

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertha Cohen
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 13, 1883

8. AGE: Years	Months	Days	If less than one day
62	2	9	..... hrs. ..... min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: Watch Maker
11. Industry or business:
FATHER 12. Name: Samuel Cohen
13. Birthplace: Baltimore
MOTHER 14. Maiden name: Fanny Sandorf
15. Birthplace: Baltimore
16. Informant: Mrs. Bertha Cohen
Address: 2220 Lyndhurst Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 25 -45- (month) (day) (year)
Cemetery or crematory: Balto Hebrew Friendship
Location: Belair Rd & North ave
18. Funeral director: J Ahrens & Co
Address: 2432 Reisterstown Rd
19. 9/27/45 (Date rec'd by registrar) H. L. Lindsay Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 22 19 45 at 7:45 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to:	
Due to: Cardiovascular disease	
Other conditions: Sudden death	
Inquiry	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: 1010 Leadenhall Date signed: 9-22-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

8

Reg. Dist. No. 08757 32

1. PLACE OF DEATH:
County: Balto.
City or town: Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Augsburg Home, Campfield Rd.
How long in hospital or institution? 7 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balto
City or town: Balto. Co.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 306 Beechfield Ave.
(If rural give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Louisa KIRK Knop Coles

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: William M. Coles
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr. 29, 1866

8. AGE: Years	Months	Days	If less than one day
79	4	4	hrs. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Andrew Konrad Petz
13. Birthplace: Baltimore
MOTHER 14. Maiden name: Elizabeth Knop
15. Birthplace: Balto.
16. Informant: Records of The Augsburg Home
Address: Campfield Rd. Balto. Co., Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-8-45. (month) (day) (year)
Cemetery or crematory: Greenmount Cem.
Location: Greenmount Ave & North Ave.
18. Funeral director: L. Heemann & Son
Address: 32 S. Broadway
19. 9/7 (Date rec'd by registrar) 1945 B.H. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 6th 1945, at 12:10 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July - 15 - 45 to Sept 6th 1945
and that I last saw her alive on Sept 6th 1945

Immediate cause of death	DURATION
1.) Cerebral Sclerosis	5 yrs
Heart Disease	
Due to	
Due to	
Other conditions - Chronic Gall Bladder	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Earl L. Chambers M. D., or other
Address: 4108 Liberty Hts Date signed 9/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

68758

★ Reg. Dist. No. 44

1. PLACE OF DEATH:

County BALTO.

City or town MIDDLERIVER
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
BORQUE AVE.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 40 YRS.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of motber)

State MD. County BALTO.

City or town MIDDLERIVER Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. BORQUE AVE.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR NO

3. (a) FULL NAME JOHN R. COMBS

3. (b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ANNA COMBS

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 3 1876

8. AGE: Years	Months	Days	If less than one day
69	0	7	hrs. min.

9. Birthplace VIRGINIA
(Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business

FATHER 12. Name WILLIAM W. COMBS

13. Birthplace VA.

MOTHER 14. Maiden name MARY BROWN

15. Birthplace VA.

16. Informant MARGARET WIATROWSKI (SAUGHTER)

Address BORQUE AVE. MIDDLERIVER

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof SEPT. 13/45 (month) (day) (year)

Cemetery or crematory MT. CARMEL

Location ODONNELL ST.

18. Funeral director Lally & Zeiler Inc.

Address 403 S. WOLFE ST.

19 SEPT. 12 19 45 (Date rec'd by registrar) John H. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 10 19 45, at 6/10 PM.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 5 19 45 to Sept 10, 19 45, and that I last saw h[illegible] alive on Sept 10 19 45.

Immediate cause of death	DURATION
Bronchopneumonia.	5 days
Due to	
Due to	
Other conditions Generalized Arteriosclerosis 2yrs.	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lenard M. Schmuck M. D. or other

Address Essex Md Date signed 9/11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

68759

Reg. Diat. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Ford's Convalescent Home 5501 Edmondson Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5205 Old Frederick Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Clara M. Corkran

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: late Charles M. Corkran
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb. 15, 1866

8. AGE: Years	Months	Days	If less than one day
79	7	15	hrs. min.

9. Birthplace: Balto. Md
(Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: Henry Seebo
13. Birthplace: Md
MOTHER 14. Maiden name: Elizabeth Egan
15. Birthplace: Md
16. Informant: Mrs. Maud C. Clements
Address: 5205 Old Fredk. Rd.
17. Burial (Burial, cremation, or removal? Which?) Date thereof: Oct. 3/45 (month) (day) (year)
Cemetery or crematory: Loudon Pk
Location: 3801 Frederick Road
18. Funeral director: Harry H. Nitzke
Address: 401 Edmondson Ave
19. 10/3 19 45 (Date rec'd by registrar) W. C. Andreae Registrar
Deputy Local Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sep. 30, 1945, at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1, 1940, to Sep. 30, 1945
and that I last saw h[er] alive on Sep. 25, 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 yrs
Due to: Arteriosclerosis	2,
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Eugene L. Pessagno M. D. or other
Address: 514 Dunray Lane Date signed: 10/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

8760

Reg. Dist. No. 42

1. PLACE OF DEATH:

County: Balto

City or town: Halethorpe

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr

Hospital, Institution, or street address where death occurred: Bost Blvd + Sueffen Spring Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Halethorpe

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Sueffen Spring + Bost Rd

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Hattie V Connell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Rufus Connell

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): July 16, 1878

8. AGE: Years	Months	Days	If less than one day
57	4	1	...hrs. ...min.

9. Birthplace: Va (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Harrison Cummings

13. Birthplace: Va

MOTHER 14. Maiden name: Mary Myers

15. Birthplace: Va

16. Informant: Rufus Connell

Address: Halethorpe Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-18-25 (month) (day) (year)

Cemetery or crematory: Levin

Location: Leesburg Va

18. Funeral director: Lloyd Hansin

Address: Laurel Md

19. Sept 17 19 25 (Date rec'd by registrar) Geo W Kieffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 15 19 25, at 12-30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Acute Cardiac failure	
Due to: Cardio vascular disease	
Due to:	
Other conditions: sudden death	
Injury	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geo. W. Kieffer Coroner Balto Co Md (M. D. or other)

Address: 1010 Leadenhall Date signed: 9-19-25

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

CERTIFICATE OF DEATH

08761

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 10 mos., 0 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 10 mos., 0 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 49 S. Arlington Avenue (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: James Costellos

3.(b) Social Security Number: 213-14-3532

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anita Costellos

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): October 26, 1893

8. AGE: Years	Months	Days	If less than one day
51	10	18	hrs. min.

9. Birthplace: Sparta, Greece (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business:

FATHER — 12. Name: Charles Costellos

FATHER — 13. Birthplace: Greece

MOTHER — 14. Maiden name: Stella Goumboulas

MOTHER — 15. Birthplace: Greece

16. Informant: James Costellos

Address: 49 S. Arlington Ave., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 15, 1945 (month) (day) (year)

Cemetery or crematory: Greek Cemetery (Evangelismos)

Location: Windsor Mill Rd., Balto., Md.

18. Funeral director: O. Durward Covington

Address: 21 W. 25th St., Balto., Md.

19. Sept. 13, 1945 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 13, 1945, at 3:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 13, 1944 to Sept. 13, 1945 and that I last saw him alive on September 13, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 yr. 11 mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Syphilis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: No operation Date of op.:

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D. M. D. or other

Address: Mount Wilson, Md. Date signed: 9/13/45

Rec'd 9-15-45 Dr. E. E. Nichols - mm

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B3a)

CERTIFICATE OF DEATH

68762

Reg. Dist. No. 44

P

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 334 E. 22nd St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: WILLIAM H. CRANSTON

3.(b) Social Security Number: 247-20-3996

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nete Page Cranston
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): 8-19-1894

8. AGE:

Years	Months	Days	If less than one day
51	0	22	...hrs. ...min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual occupation: Construction Engr.
11. Industry or business
FATHER 12. Name: Lawrence Cranford
13. Birthplace: Baltimore, Maryland
MOTHER 14. Maiden name: Mollie Haile
15. Birthplace: Baltimore, Maryland
16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 14-45 (month) (day) (year)
Cemetery or crematory: Fort
Location: Fort Baltimore md
18. Funeral director: A Bailey Slade
Address: 4907 York Road
19. 9/13/45 (Date rec'd by registrar) D.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 11 1945 at 5:50 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...
and that I last saw h... alive on ...19...

	DURATION
Immediate cause of death: Cerebral Hemorrhage	2 Weeks
Due to: Hypertension, arterial	Unknown
Due to:	
Other conditions: Hemiplegia left, Pneumonia right upper lobe	

(Include pregnancy within 3 months of death)

Major findings of operations:
...Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: David A Robertson Comdr MC
M. D. or other
Address: Fort Howard MD Date signed 9/11/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Ba)

CERTIFICATE OF DEATH

8763

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred: Spring Grove State Hospt
How long in hospital or institution? 2 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1133 Hollins Av
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Virginia Cross

3. (b) Social Security Number: 218-03-7887

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: George Cross
6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): Oct. 21, 1901

8. AGE: Years 43 | Months 10 | Days 12 | If less than one day: hrs. min.

9. Birthplace: W. Va
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER
12. Name: Hunt McKinney
13. Birthplace: W Va

MOTHER
14. Maiden name: Bertha Dowling
15. Birthplace: W Va

16. Informant: Spruce Fork Hospt Nurses
Address: Edmonds Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-12-45 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Baltimore
18. Funeral director: Frederick A. Cole
Address: 1200 W. Lombard St.
19. Sept 11 19 45 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 9 1945 at 6 15 P.M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Sept 2 1945, to Sept 9 1945 and that I last saw her alive on Sept 9 1945

Immediate cause of death	DURATION
Uremia	Before 9-7-45
Due to: acute Myocarditis	" " "
Hypertension	" " "
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John A. Kunkel M.D.
M. D. or other
Address: Catonsville Md. Date signed 9-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

CERTIFICATE OF DEATH

08765

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Rural - Sp. Point.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Theodore Roosevelt Cureton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Amanda
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 4, 1912

8. AGE: Years	Months	Days	If less than one day
33			hrs. min.

9. Birthplace: N. Carolina (Town, county, and state)
10. Usual occupation: Sky Worker
11. Industry or business: Sparrows Point
FATHER — 12. Name: Ben Cureton
13. Birthplace: N. C.
MOTHER — 14. Maiden name: Ida Huey
15. Birthplace: N. C.
16. Informant: Amanda Cureton
Address: 1203 N. Caroline St.
17. Remodal (Burial, cremation, or removal. Which?) Date thereof: Sept 12/45 (month) (day) (year)
Cemetery or crematory:
Location:
18. Funeral director: Mrs. Robt A. Elliott Daughter
Address: 1129 N. Caroline St.
19. 9/8 (Date rec'd by registrar) 19 45 John H. Cornell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-8-45 19 at 8:32 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Fractured Skull	
Fractured Left Jaw.	
Due to	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 9-8-45
Where did injury occur? N. Sp. Pt. (City or town) Balto. Co. (County) (State)
Injured at home, farm, industry, public place (where?): Public Place
Means of injury: Auto struck by Injured at work? No

23. SIGNATURE: Wm. F. Weaver M.D. M. D. or other
Address: Dundalk Md. Date signed: 9/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

CERTIFICATE OF DEATH

Reg. Dist. No. 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: BALTIMORE

City or town: CATONSVILLE MD. (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): LIFE

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: MD. County: BALTO.

City or town: CATONSVILLE Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 28 BISHOPS LANE (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: NO

3. (a) FULL NAME: ANNA M. CUSACK

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife: EDWARD P. CUSACK

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): APR. 17 1891

8. AGE: Years	Months	Days	If less than one day
54	4	22	hrs. min.

9. Birthplace: BALTIMORE MD. (Town, county, and state)

10. Usual occupation: HOUSE WIFE

11. Industry or business: AT HOME

FATHER 12. Name: JOHN J. MATEY

13. Birthplace: AUSTRIA

MOTHER 14. Maiden name: ANNA M. SCHULTZ

15. Birthplace: GERMANY

16. Informant: EDWARD P. CUSACK (HUSBAND)

Address: 28 BISHOPS LANE

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: SEPT. 12/45 (month) (day) (year)

Cemetery or crematory: SACRED HEART

Location: GERMAN HILL ROAD

18. Funeral director: Tilly & Zeller

Address: 403 S. WOLFE ST.

19. 9-11 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPT. 8 19 45, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 7 19 45 to Sept 8 19 45 and that I last saw h alive on Sept 8 19 45.

Immediate cause of death	DURATION
Carcinoma of Rectum	5 yrs
Due to	
Due to	
Other conditions Chr. Myocarditis	

(Include pregnancy within 3 months of death)

Major findings: CA of Rectum

Of operations

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Bruce Stowell M. D. or other

Address: Catonsville Md. Date signed: 8-46

68766

Evidence for change of name of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (34)

CERTIFICATE OF DEATH

FILE No. G 98 SEP 18 1945

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 1412 Reisterstown Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1412 Reisterstown Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Nannie A. Amma Davis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 9, 1876

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
69	7			

8. Birthplace: Frederick Co. Md. (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: Patrick Davis
13. Birthplace: Ireland

MOTHER
14. Maiden name: Margaret Finn
15. Birthplace: Ireland

18. Informant: Miss Alice Hanna
Address: 1412 Reisterstown Rd. Pikesville

17. Buried (Burial, cremation, or removal. Which?) Date thereof 9/10/45 (month) (day) (year)
Cemetery or crematory: Cathedral
Location: Baltimore

18. Funeral director: Martin Fahey & Sons
Address: 1827 W. North Ave.

19. 9-7-45 Dr. E. E. Nichols
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 7th 1945, at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15 1945, to Aug 7- 1945, and that I last saw her alive on Aug 6 1945.

	DURATION
Immediate cause of death: Cerebral Embolism	Sept 1-45
Due to: Arteriosclerosis	?
Due to: Arterial Hypertension	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: E. E. Nichols M.D.
M. D. or other
Address: Pikesville 8 Md. Date signed 9-7-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-d)

CERTIFICATE OF DEATH

C 8767

Reg. Dist. No. 41

1. PLACE OF DEATH:

County: Baltimore

City or town: Dundalk - 22

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 5 years

Hospital, institution, or street address where death occurred:

1747 Brookview Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto.

City or town: Dundalk - 22

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1747 Brookview Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Helen Theresa Debo

3. (b) Social Security Number: 184-05-1012

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: James Rupert Debo

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Sept 12, 1866

8. AGE:

Years	Months	Days	If less than one day
79	0	16	23 hrs. 15 min.

9. Birthplace: Gordon, Pa.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: James Weldon

13. Birthplace: Ireland

MOTHER

14. Maiden name: Cecilia O'Halleran

15. Birthplace: Ireland

18. Informant: Mrs. James Rupert Debo

Address: 1747 Brookview Rd.

17. (Burial, cremation, or removal. Which?) Removal Date thereof 9/30/45 (month) (day) (year)

Cemetery or crematory: St. Marys

Location: Mt. Carmel Pa.

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul St.

19. 9/30/45 19 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 29 19 45 at 11 15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 12 19 44 to Sept 29 19 45

and that I last saw h[illegible] alive on Sept 29 19 45

Immediate cause of death	DURATION
Malignancy of Left Lung	(1 year
Due to (Type Undetermined)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: (Pleural Thoracentesis + X Rays at Mercy Hospital - Balto Md) Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Howard Burns M.D.

M.D. or other

Address: 5[illegible] Dundalk Ave Date signed: Sept 29, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-5)

08768

CERTIFICATE OF DEATH

Reg. Diat. No. 43

1. PLACE OF DEATH:

County: Baltimore ~~Golden Ring Rd.~~

City or town: Raspeburg Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 Yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Raspeburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6612 Golden Ring Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Nunzia De Luzio or De Luzzia.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: late Gennaro De Luzio

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 25 1864

8. AGE: Years	Months	Days	If less than one day
81	5	23	..... hrs. ..... min.

9. Birthplace: Torricella Peligna Italy (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: Home

FATHER — 12. Name: ?

13. Birthplace: Italy

MOTHER — 14. Maiden name: ?

15. Birthplace: Italy

16. Informant: Mary Di Legge (Daughter)

Address: 6612 Golden Ring Rd. (Raspeburg Md.)

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 26 1945 (month) (day) (year)

Cemetery or crematory: St. Vincent

Location: Baltimore Md.

18. Funeral director: Frank Della Rocca

Address: 52 N. Morley St.

19. 9/24 (Date rec'd by registrar) 19 45 A. W. Hadwell M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 23 19 45, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 20 19 45 to Sept 23 19 45 and that I last saw h[illegible] alive on Sept 22/45. 19

Immediate cause of death	DURATION
Cerebral thrombosis	
& hemiplegia	2 days
Due to	
Due to	
Other conditions: General arteriosclerosis, etc.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Harvey L. Fuller MD M. D. or other

Address: Ridge Road, Rout 6 md Date signed: 9/23/45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

08769

★ Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Parkville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

7810 Oak Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Parkville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7810 Oak Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: PETER DENNE

3.(b) Social Security Number: 175-03-6763

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Christina C. Denne

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 29th, 1889

8. AGE: Years	Months	Days	If less than one day
55	10	5	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Brewer

11. Industry or business: Free State Brewery

FATHER — 12. Name: John Denne

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Gertrude -----

MOTHER — 15. Birthplace: Germany

16. Informant: Mrs. Peter Denne

Address: 7810 Oak Ave., Parkville, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 8, 1945 (month) (day) (year)

Cemetery or crematory: Moreland Memorial Park

Location: Baltimore, Md.

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Road

19. Sept 10 1945 (Date rec'd by registrar) D. M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 4th, 1945 at 3:05P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/18/45 1945 to 9/4/45 1945 and that I last saw h. alive on 9/3/45 1945

Immediate cause of death	DURATION
Coronary thrombosis	2 weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Harold A. Grotz, M.D. M. D. or other

Address: 8100 Harford Rd. Date signed: 9/5/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08770

Reg. Diat. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1221 N. Calvert Street, Balto., Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW II

3.(a) FULL NAME

THOMAS F. DENSMORE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 31 1918

8. AGE: Years	Months	Days	If less than one day
27	0	29	..... hrs. ..... min.

9. Birthplace: Stoystown, Pennsylvania
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business

FATHER
12. Name: Edgar Densmore
13. Birthplace: Maryland

MOTHER
14. Maiden name: Martha Clist
15. Birthplace: Maryland

16. Informant: Vets. Adm. Fac. Fort Howard, Md.
Address: Fort Howard, Maryland

17. Burial Removal Date thereof Sept 30 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Morgantown W. Va.

Location:

18. Funeral director: H. Bailey Slade

Address: 4907 York Rd Baltimore

19. Sept 30 1945 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 30 1945, at 2:15a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 1945 to September 30 1945 and that I last saw him alive on September 30 1945

Immediate cause of death	DURATION
Rheumatic Heart Disease, Mitral stenosis and insufficiency; aortic	2 years
Due to: insufficiency; myocardial damage;	
myocardial insufficiency; auricular	
Due to: fibrillation.	
Other conditions: Nephritis, acute	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: A.M. Balter M. D. or other

Address: Fort Howard, Maryland Date signed 9/30/45

A.M. BALTER, LT COL. M.C. Clinical Director

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

08771

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore 315 Ingleside Ave.
City or town Catonsville Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Catons Convalescent Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 920 Hewington Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Alexander Dodd

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Married

6.(b) Name of husband or wife Laurinne Stevens
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 15 1865

8. AGE: Years	Months	Days	If less than one day
79	11	13	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name Alexander Dodd
13. Birthplace Maryland

MOTHER
14. Maiden name Katherine Gore
15. Birthplace ?

16. Informant Mrs. Helen K. Brown
Address 301 E. 29th St. BALT, MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 1/1945 (month) (day) (year)
Cemetery or crematory Wesley Chapel CEMETERY
Location Kent Co. Maryland
18. Funeral director John O. Mitchell & Sons inc.
Address 1900 Eutaw Place Balt. Md.

19. 9/30 1945 (Date rec'd by registrar) H. C. Andrade Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1945, at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1945, to Sept 28 1945 and that I last saw h. alive on Sept. 28 1945

Immediate cause of death	DURATION
Arteriosclerotic cardiovascular disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm A. Kochman M.D.
M. D. or other
Address 3921 Edmondson Ave. Date signed 9/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

8772

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore

City or town Stevenson, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Stevenson
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert Harvey Eckert, Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1943

8. AGE: Years	Months	Days	If less than one day
2	5	23	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Robert H. Eckert. Sr.

13. Birthplace Maryland

MOTHER 14. Maiden name Catherine M. Atkinson

15. Birthplace Maryland

16. Informant Robert H. Eckert Sr.

Address Stevenson, Md

17. Burial Date thereof Sept 13, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Popular

Location Balto Co. Md

18. Funeral director Chenoweth & Donovan

Address 3615-17 Chestnut Ave.

19. 9-11-1945 E. E. Nichols Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1945, at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1945, to Sept 10 1945 and that I last saw h alive on between alive 19

Immediate cause of death	DURATION
Drowning	2 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None. Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9-10-'45

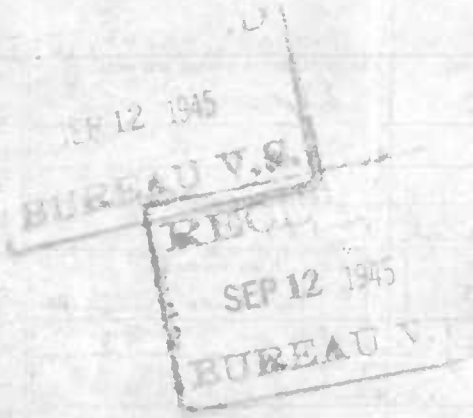
Where did injury occur? Stevenson (City or town) Balto. (County) Md (State)

Injured at home, farm, industry, public place (where?) Swimming Pool

Means of injury Drowned. Injured at work? No.

23. SIGNATURE D. D. Caples, M. D.
M. D. or other

Address Reisterstown, Md Date signed 9-10-'45


SEP 12 1945
BUREAU V.S.
SEP 12 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

08773

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Days

Hospital, Institution, or street address where death occurred:

Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3333 Piedmont Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I ✓

3.(a) FULL NAME: JAMES L. EDENFIELD

3.(b) Social Security Number: 705-05-5115

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	~~Widowed~~ Single

6.(b) Name of husband or wife: ~~Widowed~~

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 4-25-83

8. AGE: Years	Months	Days	If less than one day
62	4	28	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Railroad - B & O.

FATHER 12. Name: James Harrison Edenfield

13. Birthplace: ? Md.

MOTHER 14. Maiden name: Ida E. Kirwan

15. Birthplace: ? Md.

16. Informant: Clinical records, Vets. Adm. Facility

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-27-45 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore

18. Funeral director: Leonard J. Luck

Address: 5305 Harford Rd.

19. 9-25 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 24, 1945, at 1:18 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 21, 1945, to September 23, 1945 and that I last saw him alive on ..... 19.....

Immediate cause of death	DURATION
Pneumonia lobular	8 Days
Due to	
Due to	
Other conditions: Bronchitis, chr.	25 Yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A.M. Balter

A.M. BALTER, LT.COL., M.C. CLIN.DIR.

Address: Ft. Howard, Md. Date signed: 9-24-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a1)

CERTIFICATE OF DEATH

08774

Reg. Dist. No. 32

1. PLACE OF DEATH:
County Balto.
City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro infants give residence of mother)
State Md. County Balto.
City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Upland & Cliveden Roads
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME Ella M. Eichorn

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Lawrence A. Eichorn
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 22, 1873

8. AGE: Years	Months	Days	If less than one day
72	2	28	..... hrs. ..... min.

9. Birthplace Indiana
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Emanuel Babylon
13. Birthplace Md.

MOTHER
14. Maiden name Caroline Powell
15. Birthplace Md.

16. Informant Mrs. Rita Simmons
Address Pikesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 22, 1945 (month) (day) (year)
Cemetery or crematory Meadow Branch
Location Carroll Co.
19. Funeral director J. F. Bline & Sons
Address Reisterstown, Md.

19. 9-22-1945 (Date rec'd by registrar) Dr. E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19th 1945, at 11:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 19th 1945 to Sept 19th 1945 and that I last saw h[illegible] alive on Sept 19th 1945

Immediate cause of death	DURATION
Angina Pectoris	1 day
Due to Coronary Sclerosis	17 yr.
Due to Hypertension	2 yr.
Other conditions	
Hypertension (Include pregnancy within 3 months of death)	5 yrs.

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE James A. Miller M. D. M. D. or other
Address Pikesville 8, Md. Date signed 9/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH 18775

1. PLACE OF DEATH

County BALTO Registration Dist. No. 42

Village ~~or City~~ ARBUSTUS No. 1228 ELM RIDGE Rd. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in ~~city or~~ town where death occurred 15 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME FREDERICK C. EICHHORN

(a) Residence: No. 1228 ELM RIDGE Rd. ~~Ward.~~ 13TH DISTRICT

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. ~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~ (write the word)
MALE	WHITE	MARRIED

5e. If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ MINNIE EICHHORN

6. DATE OF BIRTH (month, day, and year) MAY 8 1882

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	3	30	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. FORMAN

9. Industry ~~or~~ business in which work was done, as SILK MILL, SAW MILL, BANK, etc. GASTELEC CO

10. Date deceased last worked at this occupation (month and year) MAY 1944

11. Total time (years) spent in this occupation 35 YRS

12. BIRTHPLACE (city or town) (State or country) BALTO MD.

FATHER

13. NAME CHAS EICHHORN

14. BIRTHPLACE (city or town) (State or country) GERMANY

MOTHER

15. MAIDEN NAME BARBARA DUPSER

16. BIRTHPLACE (city or town) (State or country) GERMANY

17. INFORMANT MINNIE EICHHORN

(Address) 1228 ELM RIDGE Rd.

18. BURIAL, CREMATION, OR REMOVAL

Place LODGE PK CEMETERY Date 9/10/45, 19

19. UNDERTAKER GEO LEIMBACH

(Address) 525 N LYNDHURST ST

20. FILED 9/10 45 A. W. Hedrick D'M Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Sept 9 1945

(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from 8/15, 19 45, to 9-7-45, 19 45

I last saw h~~im~~ alive on 9/7 3 P, 19 45; death is said to have occurred on the date stated above, at 3 P m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Acute Cardiac Failure	9/7/45
Other Contributory Causes of Importance: Cardiorespiratory Renal Disease	yrs

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Joseph L Faulkner M. D.

(Address) 13 E Washington Blvd

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a **clerk**.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4c)

CERTIFICATE OF DEATH

08776

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Baltimore
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 117 Williams Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war --

3. (a) FULL NAME Minnie Eierman

3. (b) Social Security Number none

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Henry Eierman
6.(c) If alive, give age ...... years
7. Birth date of deceased (mo., day, yr.): July 20th.1869

8. AGE: Years 76 Months 1 Days 17 If less than one day ...... hrs. ...... min.

9. Birthplace: Germany
(Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: ---- Groskopf
13. Birthplace: Germany

MOTHER
14. Maiden name: -------
15. Birthplace: Germany

16. Informant: Mrs.Minnie Gessner
Address: 117 Williams Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept.10/45 (month) (day) (year)
Cemetery or crematory: Chestertown Cem.
Location: Chestertown Md.

18. Funeral director: Philip Herwig Sons
Address: 2024 Orleans St.

19. 9/9/45 (Date rec'd by registrar) 19 Wm Carman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7th 19 45 at 4:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19 43 to Sept 7 19 45
and that I last saw h er alive on Sept 7th 19 45

Immediate cause of death: Carcinoma gall bladder — DURATION: 1 yr
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ...... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ...... Injured at work?

23. SIGNATURE David H. Andrews M.D. (M. D. or other)
Address 2 Kinsley Rd Dundalk Md
Date signed 9/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

18777 P

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Anneslie,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore,

City or town: Anneslie,

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 515 Dunkirk Road,

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary Ella Emerick,

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: David L. Emerick

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 27, 1861

8. AGE: Years	Months	Days	If less than one day
84	0	16	..... hrs. ..... min.

9. Birthplace: Baltimore City,

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at home

FATHER — 12. Name: John Lindenman,

FATHER — 13. Birthplace: Germany,

MOTHER — 14. Maiden name: Mary Louisa Gillingham,

MOTHER — 15. Birthplace: Baltimore City,

16. Informant: David L. Emerick,

Address: 515 Dunkirk Road,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/15/45 (month) (day) (year)

Cemetery or crematory: Greenmount,

Location: Baltimore City,

18. Funeral director: C. Vernon Lemmon.

Address: 4611 Park Heights, Balto. Md.

19. 9-14-45 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 13, 1945 at 4. A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-2- 1945 to Sept. 1945 and that I last saw her alive on Sept. 12th 1945

Immediate cause of death	DURATION
1 Cardiac Exhaustion	10ds.
Due to: Chron Mitral Endo-carditis	unknown
2 Due to: Senility	10yrs.
3 Other conditions: Probable Carcinoma of Ovary	unknown

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. D. Ensor M. D. or other

Address: 7201 York Rd Date signed: 9-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (192)

08778

CERTIFICATE OF DEATH

★ Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Balto.
City or town: Dundalk or Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Dietman Dud Bank
How long in hospital or institution? Of Helabird ave

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Dundalk Grow Manor
(If outside city or town limits, write RURAL and give nearest town)
Street No. 251 W. Woodwell Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sonia Enke

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	White	(Married)

6.(b) Name of husband or wife: Robt Arnold Enke
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Jan 27/1915.

8. AGE: Years	Months	Days	If less than one day
30.	7	11	..... hrs. ..... min.

9. Birthplace: (S. Dakota) (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: own home
FATHER 12. Name: Henry Kaufer.
FATHER 13. Birthplace: S. Dakota.
MOTHER 14. Maiden name: Sobel Sonia.
MOTHER 15. Birthplace: Russia.
16. Informant: Robt A. Enke.
Address: 251 W. Woodwell Rd. Dundalk
17. (Burial, cremation, or removal. Which?) Burial Date thereof 9/7/45. (month) (day) (year)
Cemetery or crematory: Moreland Park
Location: Balto Co.
18. Funeral director: John L. Connelly
Address: Essex Md
19. (Date rec'd by registrar) 9/5/45 19.. Registrar: W M Learmont

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 9 19 45, at 1:45 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 9 19 45, to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Electric Shock	
Due to: (Hit by Lightning)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 9/9/45.
Where did injury occur? Dundalk (City or town) Balto (County) Md. (State)
Injured at home, farm, industry, public place, (where?) Truck farm.
Means of injury: Lightning Injured at work? No

23. SIGNATURE: W M Learmont M.D.
M. D., or other
Address: Dundalk Deputy medical examiner
Date signed 9/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 192

CERTIFICATE OF DEATH

★ 08779

Reg. Dist. No. 41

1. PLACE OF DEATH:

County: Balto

City or town: Dundalk 22 Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Dietman Sand Bank

How long in hospital or institution? 7y Holabird ave

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Dundalk 22

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2514 W. Woodwell Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sonnia Elizabeth Enke

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 1 1941

8. AGE: Years 4 | Months 5 | Days 8 | If less than one day ... hrs. ... min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual occupation none

11. Industry or business none

FATHER 12. Name Robt Arnold Enke.

FATHER 13. Birthplace

MOTHER 14. Maiden name Sonnia Elizabeth Enke

MOTHER 15. Birthplace S. Dakota.

16. Informant Robt Arnold Enke

Address 2514 W. Woodwell Rd Dundalk

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/17/45 (month) (day) (year)

Cemetery or crematory Moreland Park.

Location Balto. Co.

18. Funeral director John J. Connelly.

Address Essex, Md.

19. 9/15/45 (Date rec'd by registrar) J M Learmont Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 19 45, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Electric Shock	
Due to Hit by lightning	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9/9/45

Where did injury occur? Dundalk (City or town) Balto. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Work - farm

Means of injury Lightning Injured at work? Yes

23. SIGNATURE J M Learmont M.D. M. D. or other

Address Dundalk Md. Date signed 9/14/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

08780 P

CERTIFICATE OF DEATH

Reg. Dist. No. 24

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

I

1. PLACE OF DEATH:
County: Baltimore 19.
City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Shadyside Lane.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: as in #1.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Albert Mc Leand Evans.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Margaret Virginia Evans
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Sept. 19. 1883.

8. AGE: Years	Months	Days	If less than one day
61	11	29	hrs. min.

9. Birthplace: Balto. Co. Md.
(Town, county, and state)
10. Usual occupation: Electrician
11. Industry or business:
FATHER 12. Name: John Evans.
13. Birthplace:
MOTHER 14. Maiden name: Louisa.
15. Birthplace:
16. Informant: Margaret V Evans.
Address: as in #1.
17. Burial (Burial, cremation, or removal, Which?) Date thereof Sept 22-45 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Balto Md
18. Funeral director: Ellsworth Armacost
Address: 3911 Liberty Heights Ave
19. 9-20 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 18 19 45 at 4.45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 19 47 to Sept 18 19 45
and that I last saw him alive on Sept. 18 19 45

Immediate cause of death	DURATION
Coronary Occlusion.	1 hour
Due to: Hypertensive Cardio Vascular Disease.	2 yrs.
Due to:	
Other conditions:	

(include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Louis N. Hollin M.D. M. D. or other
Address: Sparrows Pt Md Date signed SEP 18 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P 118843 D

Reg. Diat. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore-30

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1409 Light Street

(If rnral, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Jones ~~Evelius~~ Evelius

3.(b) Social Security Number 213-01-7268

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 29, 1885

8. AGE:	Years	Months	Days	If less than one day
	60	5	16	hrs. min.

9. Birthplace: Vineland, N. J. (Town, county, and state)

10. Usual occupation: Glass worker

11. Industry or business: Glass works

FATHER 12. Name: Frederick Evelius

FATHER 13. Birthplace: Sweden

MOTHER 14. Maiden name: Augusta Nyholm

MOTHER 15. Birthplace: Sweden

16. Informant: Hospital records

Address: Catonsville, Balto.-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 15-45 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Balto. Md.

18. Funeral director: Bernard C. Harle

Address: 121 E. West St

19. 9-14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 12 1945 at 7:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1945 to September 12 1945 and that I last saw him alive on September 12 1945

	DURATION
Immediate cause of death: Pulmonary oedema	1 day
Due to: Chronic myocarditis (luetic)	Indef.
Due to: Secondary anaemia	"
Other conditions: Tabo-paresis	"

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.

Robert E. Gardner, M.D. M. D. or other

Address: Balto.-28, Md. Date signed: 9/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 72-G

CERTIFICATE OF DEATH

08781 P

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore

City or town Ruxton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs.

Hospital, institution, or street address where death occurred: at home

How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore County

City or town Ruxton

(If outside city or town limits, write RURAL and give nearest town)

Street No. Ruxton Road

(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Lucy Rice Everton ~~Everton~~

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Rev. Wallace R. Everton

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Dec. 31 1890

8. AGE: Years 54 | Months 8 | Days 13 | If less than one day: hrs. min.

9. Birthplace: New York City (Town, county, and state)

10. Usual occupation: Home

11. Industry or business: —

FATHER — 12. Name: John F. Rice

13. Birthplace: not known

MOTHER — 14. Maiden name: Lucy A. Letton

15. Birthplace: not known

16. Informant: Miss Lucy L. Everton (daughter)

Address: Ruxton Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 17 45 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore Md.

18. Funeral director: Stewart Mort. Co.

Address: 108 W. Mt. Vernon Balto.

19. Sept. 15 1945 (Date rec'd by registrar) A. W. Hetrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 13 1945 at 10½ P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Heart disease, vascular coronary thrombosis	9/13/45
Due to: Rheumatic heart disease c. valvular involvement mitral	20-30 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Rollin G. Hudson M.D. M. D. or other

Address: Towson 4, Md. Date signed 9/14/45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08782

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 yrs., 11 mos., 15 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 16 yrs., 11 mos., 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: .....

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3502 Chestnut Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3.(a) FULL NAME ~~BARTHOLOMEW~~ Bartholomew Fahey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Fahey

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): September 22, 1875

8. AGE: Years	Months	Days	If less than one day
69	11	19	.....hrs. .....min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Baker

11. Industry or business: Bakery

FATHER 12. Name: Mark Fahey

FATHER 13. Birthplace: Ireland

MOTHER 14. Maiden name: Mary Farrell

MOTHER 15. Birthplace: Maryland

16. Informant: Hospital records

Address: Catonsville-28, Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 14-45 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Baltimore Md

18. Funeral director: Frank H. Seitz

Address: 814 N 36 St

19. 9/11 (Date rec'd by registrar) 19 45 A. W. Hedgepeth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 10 19 45 at 7:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 26 19 28, to September 10 19 45 and that I last saw him alive on September 10 19 45

Immediate cause of death	DURATION
Bilateral confluent bronchial pneumonia	7 das.
Due to: Aneurysmal dilatation of the aorta	Indef.
Due to: Generalized arteriosclerosis	"
Extensive cortical defect	
Other conditions: left temporal lobe (base)	
Origin undetermined.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robert E. Gardner, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed 9/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

08783

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs., 6 mos., 8 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 10 yrs., 6 mos., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Athol Avenue, Irvington

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Louisa ~~Faber~~ (FARBER)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Henry Faber

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ~~1850?~~ April 23, 1851

8. AGE: Years	Months	Days	If less than one day
~~94~~ 95	?	?	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER — 12. Name: ? Christian Supp

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: ? Elizabeth Crist

MOTHER — 15. Birthplace: Germany

16. Informant: Hospital records

Address: Catonsville, Balto.-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-30-45 (month) (day) (year)

Cemetery or crematory: Western

Location: Edmondson + Longwood Sts

18. Funeral director: Harry A Wiltze

Address: 4101 Edmondson Ave

19. 9/29 1945 (Date rec'd by registrar) H. C. Andrews Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 26 19 45 at 6:08 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18 19 35, to September 26 19 45

and that I last saw her alive on September 26 19 45

Immediate cause of death	DURATION
Terminal right lower lobe pneumonia	24 hrs.
Due to: Scirrhous carcinoma of the left breast	Indef.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.

Robert E. Gardner, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 9/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

08784

★ Reg. Dist. No. 40

1. PLACE OF DEATH:
County Baltimore
City or town Hotel Cliff near Towson
(If outside city or towe limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Hotel Cliff near Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sister Mary Cleta Feldmann

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1869

8. AGE: Years	Months	Days	If less than one day
76	3	7	hrs. min.

9. Birthplace Europe
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business

FATHER
12. Name Vincent Feldmann
13. Birthplace Bayden Europe

MOTHER
14. Maiden name Benedicta Streit
15. Birthplace Bayden, Europe

16. Informant Sr. Mary Clara
Address Hotel Cliff. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 21 45 (month) (day) (year)
Cemetery or crematory Hotel Cliff
Location Glen Arbor
18. Funeral director Geo M. Smith Son
Address 811 N Eutaw St

19. 9/19/45 19 W M Hammett
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18 19 45, at 9.00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13 19 45, to Sept. 18 19 45 and that I last saw h er alive on Sept 4 19 45 19

Immediate cause of death	DURATION
Coronary occlusion	2 days
Due to	
Due to	
Other conditions Cardiac sclerosis + hypertension	2

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature]
M. D. or other
Address Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P

11878 54

Reg. Dist. No. 93d

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto Co.
City or town: Rosedale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 yr.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Rosedale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8217 Phila Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary E Firestone

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: William C Firestone
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 9 1879
8. AGE: Years: 66 Months: 2 Days: 17 If less than one day: hrs. min.
9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: Home Work
11. Industry or business:
FATHER 12. Name: Conrad Eckes
13. Birthplace: Md
MOTHER 14. Maiden name: Mary E Herman
15. Birthplace: Md
16. Informant: Mrs Walter Sebastian
Address: 8217 Phila Road
17. Burial, cremation, or removal. Which?: Burial Date thereof: Sept 29 45 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Taylor Ave Balto Co.
18. Funeral director: Frederick Funeral Home
Address: 2008 Orleans St.
19. 9-28 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 26 19 45 at 2 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 19 45 to Sept 26 19 45 and that I last saw h-er alive on Sept 26 19 45 19

	DURATION
Immediate cause of death: Cerebral apoplexy	Sudden
Due to: Arteri-Sclerotic Cardio Vascular & Hypertension	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Balto 6 Md Date signed: 9/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

08786

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Paradise Cir
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Paradise Circle
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Clara V Flaherty

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Leo M Flaherty
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 4 1899

8. AGE: Years: 46 | Months: 5 | Days: 12 | If less than one day: hrs. min.

9. Birthplace: New Jersey (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Arthur Homer
13. Birthplace: N J

MOTHER
14. Maiden name: Rebecca J Parker
15. Birthplace: N J

16. Informant: Leo M Flaherty
Address: Paradise Cir Catons

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-19-45 (month) (day) (year)
Cemetery or crematory: Cathedral
Location: Baltimore Md

18. Funeral director: George C Finley
Address: Catonsville Md

19. 9/18/45 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept - 16 1945, at 8:0A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept - 11 - 1945, to Sept - 16 1945.
and that I last saw h alive on Sept - 15 - 1945.

Immediate cause of death: Coronary Occlusion — DURATION: 5 Days
Due to: Arterial Hypertension — 18 yrs
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: D.
Date of op.
Autopsy results: D
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: D Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Lloyd Johnson M. D. or other
Address: Catonsville Date signed 9/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH 08787

1. PLACE OF DEATH (Ha)

County Balto. Registration Dist. No. 44

Village or City Mt. Hayes No. Old Victory Farm Rd St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Anna Fleischmann

(a) Residence: No Old Victory Farm Rd St. Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Fleischmann

6. DATE OF BIRTH (month, day, and year) Feb. 3 1867

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
78	7	19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housework

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto. Md.

FATHER

13. NAME Wilhelm Ellwoogt

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME Not Known

16. BIRTHPLACE (city or town) (State or country) Not Known

17. INFORMANT John Fleischmann (Address) Old Victory Farm Rd.

18. BURIAL, CREMATION, OR REMOVAL Place Mt. Carmel Cem. Data Sept. 26, 1945

19. UNDERTAKER John A. Miller (Address) 2334 Jefferson St.

20. FILED Sept 25 1945 John D Connelly Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Sept (Month) 22 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1945, to ____, 19____

I last saw her alive on ____, 19____; death is said to have occurred on the date stated above, at ____ m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Coronary Thrombosis	

Other Contributory Causes of importance:

Arteria-Sclerotic-Cardio Vascular Renal Disease

Name of operation ____ Date of ____

What test confirmed diagnosis? ____ Was there an autopsy? ____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of injury ____, 19____

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ____

Nature of injury ____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify ____

(Signed) G. M. Baumgardner M. D.

(Address) Balto 6 Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants and wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

08788 P

Reg. Diat. No. 44

1. PLACE OF DEATH:
County Baltimore - 19 -
City or town Sparrows Point.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 47 yrs.
Hospital, Institution, or street address where death occurred:
3117 White May Ave.
How long in hospital or institution? 1

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ... County Balto.
City or town Aso ex #1.
(If outside city or town limits, write RURAL and give nearest town)
Street No. ...
(If rural, give LOCATION)
2.(a) If veteran, name war No -

3.(a) FULL NAME Nancy Low. Francis

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married -
6.(b) Name of husband or wife: Jacob. Brewer. Francis
6.(c) If alive, give age: 37 years
7. Birth date of deceased (mo., day, yr.): Oct 4. 1909
8. AGE: Years 35 | Months 11 | Days 26. | If less than one day ... hrs. ... min.
9. Birthplace: W. Liberty. Ky. (Town, county and state)
10. Usual occupation: Housewife
11. Industry or business: Own home -
12. Name of father: H. B. Wells
13. Birthplace of father: W. Liberty. Ky.
14. Maiden name of mother: Annie Thomas.
15. Birthplace of mother: W. Liberty Ky -
16. Informant: Annie Wells
Address: Aso pi #1.
17. Burial, cremation, or removal. Which? Removal Date thereof 10/2/45 (month) (day) (year)
Cemetery or crematory: Woodland
Location: Ironton Ohio
18. Funeral director: Nelson Cook Co.
Address: 1214 Lawrence St.
19. 10-6 1945 Received (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 30 19 45 at 11 45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July. 23. 1945 to Sept 30 1945 and that I last saw h... alive on Sept. 30. 1945

	DURATION
Immediate cause of death: Generalized metastases from	
Due to: Carcinoma breast.	1 1/2 yrs
Due to:	
Other conditions: /	

(Include pregnancy within 3 months of death)

Major findings of operations: Amputation right breast - Adenomes - Date of op. June. 1944

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Louis D. Tolin. M.D. M. D. or other
Address: Sparrows Pt. 19 Date signed 10./45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

08789

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Relay, 27, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? April 2, 1945
Hospital, institution, or street address where death occurred:
How long in hospital or institution? Relay Sanitarium

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore City
City or town [illegible]
(If outside city or town limits, write RURAL and give nearest town)
Street No. 433 Kenneth Sq.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Miss Laura Frazee

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.) Aug 6, 1868

8. AGE: Years	Months	Days	If less than one day
77	1.	0	....hrs. ....min.

9. Birthplace Baltimore City, Md.
(Town, county, and state)
10. Usual occupation Retired school teacher
11. Industry or business

FATHER
12. Name Samuel Frazee
13. Birthplace Colfax, Clinton Co. Indiana

MOTHER
14. Maiden name Nancy Beal
15. Birthplace Ross County, Ohio

16. Informant Maj. M.B. Frazee
Address 1903 Caldwell Drive, Columbus, Indiana

17. Buried Date thereof Sept 10, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Green Lawn Cemetery
Location Frankfort - Ind -
18. Funeral director Stewart & Mowen Co
Address 108 W North Av.

19. 9/7 19 45 H. C. Andreae Registrar
(Date rec'd by registrar) Deputy Loc. Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 1945 19.... at 10:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 19 45, to ....19....
and that I last saw her alive on Sept. 6, 1945. 19....

		DURATION
Immediate cause of death	Chr. Myocarditis	1 mon
Due to	Generalized Arterio Sclerosis	1 yr.
Due to		
Other conditions	Senile psychosis with cerebral arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations .... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury .... Injured at work?

23. SIGNATURE [illegible] M. D. or other
Address [illegible] Date signed 9-7

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64a)

08790 P

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?: —
Hospital, institution, or street address where death occurred:
How long in hospital or institution?: —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Govdeugh
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 504 Hatherleigh Rd
(If rural, give LOCATION)
2.(a) If veteran, name war: W

3.(a) FULL NAME: John Richard German

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Marguerite S
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Oct 29. 1905

8. AGE:

Years	Months	Days	If less than one day
39	10	9	... hrs. ... min.

9. Birthplace: States Island N Y (Town, county, and state)
10. Usual occupation: Insurance Adjuster
11. Industry or business: Self
FATHER 12. Name: Wilbur Fiske German
13. Birthplace: Baltimore Md
MOTHER 14. Maiden name: Eugenia Michael
15. Birthplace: Philadelphia Pa
16. Informant: Marguerite German
Address: 504 Hatherleigh Rd
17. Burial, cremation, or removal. Which?: Burial Date thereof: 9/11/45 (month) (day) (year)
Cemetery or crematory: Druid Ridge
Location: Pikesville Md
18. Funeral director: William Ecob Inc
Address: 1314 St Paul St
19. 9/10 19 45 A. W. Hedrick Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 8, 1945, at 4.50 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Asphyxiation by strangulation - suicide with belt.	9/8/45
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: 9/8/45
Where did injury occur? Towson Balto Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Balto. Co. Jail
Means of injury: ... Injured at work?

23. SIGNATURE: Rollin L. Hudson M.D. D.M.E.
M. D. or other
Address: Towson Md Date signed: 9/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

08791 Reg. Dist. No. 42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Hale Trail

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 yrs

Hospital, institution, or street address where death occurred: 5522 Link Ave

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Hale Thorpe

(If outside city or town limits, write RURAL and give nearest town)

Street No. 55 22 Link Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME Josephine Elizabeth Gibson

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Oscar L. Gibson

6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.): July 15 1897

8. AGE:

Years	Months	Days	If less than one day
48	1	19	... hrs. ... min.

9. Birthplace: Frederick Md (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Housework

FATHER 12. Name: Daniel F. Rawlings

FATHER 13. Birthplace: Calvert Co.

MOTHER 14. Maiden name: Mary M. Simmons

MOTHER 15. Birthplace: Calvert Co Md

16. Informant: Mrs. Oscar L. Gibson

Address: 5522 Link Ave Hale Thorpe 27 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-7-45 (month) (day) (year)

Cemetery or crematory: MEADOW RIDGE MEMORIAL

Location: WASHINGTON BLVD. DORSEY

18. Funeral director: RAYMOND KAUFMAN

Address: 1026 KEEDY AVE. BALTO-29, MD

19. Sept 7 45 (Date rec'd by registrar) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 3 1945, at 5:45 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1944, to Sept 3 1945

and that I last saw h.. alive on Sept 3 1945

Immediate cause of death	DURATION
Carcinoma of the Brain	1 yr
Due to: unknown	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of frontal lobe of Brain Date of op. Made 9/45

Autopsy results: none made

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: E E Brumbaugh M. D. or other

Address: 5609 Maryland Ave Date signed 9/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08792

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 3 mos., 13 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 3 mos., 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: 1738 E. Lombard Street
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Baltimore, Maryland
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Stephen Gostomski

3.(b) Social Security Number: 214-01-8132

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Frances Gostomski

6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): January 4, 1906

8. AGE: Years	Months	Days	If less than one day
39	8	20	...hrs. ...min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Guard

11. Industry or business:

FATHER — 12. Name: Francis Gostomski

13. Birthplace: Poland

MOTHER — 14. Maiden name: Rose Ziemba

15. Birthplace: Poland

16. Informant: Stephen Gostomski

Address: 1738 E. Lombard St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 27, 1945 (month) (day) (year)

Cemetery or crematory: Holy Rosary Cemetery

Location: German Hill Rd., Balto., Md.

18. Funeral director: Fred W. Ozazewski

Address: 1930 Eastern Ave., Balto., Md.

19. Sept. 24, 1945 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 24, 1945 at 8:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11, 1945 to Sept. 24, 1945 and that I last saw her alive on September 24, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 Yrs.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Tuberculous Enteritis	7 Mos.

(Include pregnancy within 3 months of death)

Major findings of operations: No operation Date of op.:

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D. M. D. or other

Address: Mount Wilson, Md. Date signed: 9/24/45

Rec'd by Dr. E E Nichols - 9-26-45 mw.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

18793

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 53 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 906 Frederick Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mary Agnes Harmon

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: John B. Harmon
6.(c) If alive, give age: ..... years
7. Birth date of deceased (mo., day, yr.): Jan. 21, 1866
8. AGE: Years: 79 Months: 8 Days: 9 If less than one day: ..... hrs. ..... min.
9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual occupation: Seamstress
11. Industry or business: Retired
FATHER 12. Name: John Gahgan
FATHER 13. Birthplace: Unknown
MOTHER 14. Maiden name: Bridget O'Hallen
MOTHER 15. Birthplace: Maryland
16. Informant: Mrs. Margaret C. Harmon
Address: 906 Frederick Ave. Catonsville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 3, 1945 (month) (day) (year)
Cemetery or crematory: New Cathedral Cem.
Location: Baltimore, Md.
18. Funeral director: Easton Sons
Address: 608 Frederick Ave. Catonsville Md.
19. (Date rec'd by registrar) 10/3 1945
Registrar: H. C. Linder Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 30, 1945, at 12:20 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar 12 1945, to Sept 30 1945
and that I last saw h[illegible] alive on Sept 29 1945

	DURATION
Immediate cause of death: Chr. Myocarditis	1 mon
Due to: Generalized Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: [illegible] Md. Date signed: 10/1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08794

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Carters Nursing home 16 Festing ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4807 Caleherne Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Thomas E. Hawkins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb. 12, 1864

8. AGE: Years	Months	Days	If less than one day
81	7	16	hrs. min.

9. Birthplace: Balto. Md.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Balto. Police Dept.
FATHER 12. Name: Robert Hawkins
13. Birthplace: Md.
MOTHER 14. Maiden name: Susan Rider
15. Birthplace: Md.
16. Informant: Mrs. Wm. J. Gallagher
Address: 4807 Caleherne Rd
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/1/45 (month) (day) (year)
Cemetery or crematory: Loudon Pk
Location: 3801 Frederick Rd. Balto. Md
18. Funeral director: Harry A. Mitzke
Address: 4101 E. Edmondson ave
19. 10/1 1945 (Date rec'd by registrar) V. C. Andrews Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 28/45 19 at 9.10 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 25 1945 to Sept. 28 1945 and that I last saw h.. alive on Sept. 28 1945

Immediate cause of death	DURATION
Carcin. Vascular Insufficiency	2 mo.
Due to: Hemiplegia Arterio-sclerosis	?
Due to: Senility	5 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William K. Gallagher M.D. M. D. or other
Address: Catonsville-28, Md. Date signed: 9-29-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

08795 P

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Parkville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3023 Overland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Louise Hayward

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Albert R. Hayward

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 1- 1869

8. AGE: Years: 76 | Months: 1 | Days: 15 | If less than one day: hrs. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business: Housewife

FATHER
12. Name: George H. Weaver
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden name: Mary L. Creager
15. Birthplace: Baltimore Md.

16. Informant: Mrs Bertha Hayward Institute
Address: 1919 E. 30th St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 19-1945 (month) (day) (year)

Cemetery or crematory: Western

Location: Baltimore Md.

19. Funeral director: Flynn & Fleming

Address: 1416 Light St.

19. 9-19 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 16 19 45 at 3.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 19 45 to Sept 16 19 45

and that I last saw h... alive on Sept 16 19 45

	DURATION
Immediate cause of death: Coronary Thrombosis	2 days
Due to: Arteriosclerosis	1 yr.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. T. Hoffman M.D.
M. D. or other

Address: [illegible] Date signed: 9/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

08796

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, Institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Dayton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Benjamin M. Hill

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Nellie Hill

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1866 August 9

8. AGE: Years	Months	Days	If less than one day
79	1	8	hrs. min.

9. Birthplace: Howard Co. Md. (Town, county, and state)

10. Usual occupation: farmer

11. Industry or business: farming

FATHER — 12. Name: John Hill

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Lucrecia Thompson

MOTHER — 15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-20 1945 (month) (day) (year)

Cemetery or crematory: Lutheran Chapel

Location: Clarksville Md.

18. Funeral director: J.C. Higinbotham

Address: Ellicott City Md

19. 9/18 1945 (Date rec'd by registrar) J.C. Andrews Deputy Registrar (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 17 1945, at 7:15 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 4 1945, to September 17 1945 and that I last saw h... im alive on September 17 1945

Immediate cause of death	DURATION
Broncho-pneumonia	1 day
Due to: Uremia	4 days
Due to: Hypertensive cardio-renal vascular disease	Indef.
Other conditions: Cerebral hemorrhage, right	5 days.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.

Robert E. Gardner M. D. or other

Address: Baltimore-28, Md. Date signed: 9/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

18797 46 P

Reg. Diat. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 days

Hospital, Institution, or street address where death occurred:

Vets. Adm. Fac., Fort Howard, Maryland

How long in hospital or institution? 41 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 303 Second Street

(If rural, give LOCATION)

2.(a) If veteran, name war WW II

3.(a) FULL NAME

OTIS J. HOLLAND

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife Single

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 6, 1923

8. AGE: Years	Months	Days	If less than one day
22	6	27	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Farming

11. Industry or business

FATHER 12. Name William Holland

13. Birthplace ?

MOTHER 14. Maiden name Hazel ?

15. Birthplace ?

16. Informant Clinical Records, Vets. Adm. Fac.,

Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-6-45 (month) (day) (year)

Cemetery or crematory .....

Location Salisbury, Maryland

18. Funeral director Charles R. Law

Address 802-04 Madison Avenue

19. Sept 4 19 45 (Date rec'd by registrar) A. W. Fedorick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 19 45 at 10:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23 19 45, to September 2 19 45 and that I last saw him alive on September 2 19 45

Immediate cause of death	DURATION
Peritonitis, tuberculous	unknown
Due to	
Due to	
Other conditions Broncho pneumonia	
Nephritis, chronic	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H. Y. Richards, MAJOR, M.C., AUS M. D. or other

Address Veterans Administration Fort Howard, Md. Date signed Sept. 3, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08798

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 34 Ridge Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 34 Ridge Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Gordon N Hoopes

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mildred
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 17 1889

8. AGE: Years 56 | Months 2 | Days 22 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county and state)
10. Usual occupation: None
11. Industry or business:

FATHER
12. Name: Franklin G Hoopes
13. Birthplace: Md

MOTHER
14. Maiden name: Wickelmayer Rumsey
15. Birthplace: Md

16. Informant: Mrs. G N Hoopes
Address: 34 Ridge Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-11-45 (month) (day) (year)
Cemetery or crematory: Lorraine Park
Location: Baltimore Md
18. Funeral director: Geo. A. Farley
Address: Catonsville Md.

19. 9/10 1945 (Date rec'd by registrar) [signature] Registrar
Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 8 19 45, at 10 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 19 1944 to Sept 8 1945
and that I last saw h— alive on Sept 8 1945

Immediate cause of death: Hypertrauma Cardio Vascular Disease — DURATION: 1 yr

Due to:

Due to:

Other conditions: Chr. Nephritis — 2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Catonsville Md Date signed 8-10

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08799

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 Minutes

Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 45 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: .....

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: #5 Exeter St., East End Hotel
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: ROBERT C. HUTCHERSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single ?

6.(b) Name of husband or wife: .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 20, 1888

8. AGE: Years	Months	Days	If less than one day
57	2	1	..... hrs. ..... min.

9. Birthplace: Madison, Va.
(Town, county, and state)

10. Usual occupation: Lineman

11. Industry or business

FATHER — 12. Name: Elmer T. Hutcherson
13. Birthplace: Madison County, Va.

MOTHER — 14. Maiden name: Mary Alice Carpenter
15. Birthplace: Madison County, Va.

16. Informant: Clinical records, Vets. Adm. Fac./
Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/23/45 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cem.

Location: Madison, Va.

18. Funeral director: J. C. Clore

Address: Madison, Va.

19. Sept. 22 1945 (Date rec'd by registrar) City Health Dept. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 21, 1945, at 6:15 Au

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 21, 1945 to September 21, 1945 and that I last saw him alive on September 21, 1945

Immediate cause of death	DURATION
Tuberculosis, pul., chronic, Far advanced	Unknown
Due to	
Due to	
Other conditions: Pneumothorax, left	
Displacement of the mediastinum & Heart	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: A.M. Balter

A.M. BALTER, LT. COL., M.C. CLIN. DIR.

Address: Ft. Howard, Md. Date signed 9-21-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 18810

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Balto.

City or town: Sparrows Pt. —

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Bet. Steel Co —

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MD. County:

City or town: BALTIMORE

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 336 S. Oldham Street

(If rural, give LOCATION)

2.(a) If veteran, name war: no ✓

3.(a) FULL NAME: CHARLES WILLIAM HUTCHINS

3.(b) Social Security Number: 213-09-4159

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Catherine A. Hutchins

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): August 6, 1894

8. AGE: Years	Months	Days	If less than one day
51	1	2	....hrs. ....min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Bricklayer

11. Industry or business: Beth. Steel., Sp. Pt., Md.

FATHER — 12. Name: Harry Hutchins

FATHER — 13. Birthplace: Baltimore, Maryland

MOTHER — 14. Maiden name: Mary Nitzel

MOTHER — 15. Birthplace: Baltimore, Maryland

16. Informant: Mrs. Catherine Hutchins

Address: 336 S. Oldham Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9- 12-45 (month) (day) (year)

Cemetery or crematory: Oak Lawn Cem.

Location: Baltimore, Maryland

18. Funeral director: HENRY SANDER & SONS, INC.

Address: NORTH AVE. & BROADWAY

19. 9/12 1945 (Date rec'd by registrar) O. W. Hedrick Registrar LR

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-8-45, 19..., at 10:04 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....

and that I last saw h... alive on ....19....

Immediate cause of death	DURATION
(a) Coronary Occlusion	10 Min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of ....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. Davis M.D. Asst Supt. Med. Exam. Bal. (M. D.) or other)

Address: Baltimore 24 Date signed 9/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

08801

Reg. Dist. No. 30

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County 171 Winters Lane

City or town Baltimore Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No. 171 Winters Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Florence Jackson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	married

6.(b) Name of husband or wife Perry Jackson

7. Birth date of deceased (mo., day, yr.) July 29 1909

6.(c) If alive, give age years

8. AGE: 36 Years | Months 7 | Days 29 | If less than one day ... hrs. ... min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Charles E Harding

13. Birthplace md

MOTHER 14. Maiden name Mary Pray

15. Birthplace Va.

16. Informant Perry Jackson

Address 171 Winters Lane

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-13-45 (month) (day) (year)

Cemetery or crematory Western Star Cem

Location Baltimore

18. Funeral director Mrs Frances A Hemsley

Address 578 W Biddle St

19. 9/10 19 45 (Date rec'd by registrar) [signature] Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10th 1945 at 12.55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16 1945 to Sept 10 1945

and that I last saw h er alive on Sept 10 1945

Immediate cause of death	DURATION
Aortic Insufficiency ?	
Due to Hypertensive Cardio-Renal Disease ?	
Due to	
Other conditions Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C F Maloney MD M. D. or other

Address Catonsville Md Date signed 9/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bd)

CERTIFICATE OF DEATH

118802

Reg. Diat. No. 32

1. PLACE OF DEATH:
County: Baltimore County
City or town: Rural - Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 63 years
Hospital, Institution, or street address where death occurred: Home
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore County
City or town: Rural - Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Near Garrison on Reisterstown Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: FRANCES MOALE JANNEY

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife: STUART SYMINGTON JANNEY
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): FEBRUARY 10, 1882

8. AGE: Years	Months	Days	If less than one day
63	7	11	hrs. min.

9. Birthplace: BALTIMORE COUNTY, MARYLAND (Town, county, and state)
10. Usual occupation: HOUSEWIFE
11. Industry or business: NONE

FATHER
12. Name: JERVIS SPENCER
13. Birthplace: CHESTERTOWN, MARYLAND

MOTHER
14. Maiden name: SARAH ELIZABETH ELDER
15. Birthplace: BALTIMORE COUNTY, MARYLAND

16. Informant: STUART S. JANNEY, JR.
Address: GLYNDON P.O., BALTIMORE CO., MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 22/45 (month) (day) (year)
Cemetery or crematory: St Thomas
Location: Garrison Forest Md
18. Funeral director: Henry W. Jenkins Sons Co
Address: McCulloh & Eutaw sts

19. 9/22 1945 (Date rec'd by registrar) C W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 21st. 1945, at 2:15 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 10th 1945, to Sept. 21st 1945
and that I last saw h[illegible] alive on Sept. 21st/45 1945

Immediate cause of death	DURATION
arterio-sclerotic heart disease.	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wade B. Allen M. D. or other
Address: 6 E. Cooper St. Date signed: Sept 21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Read 9/22/45

V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08803

★ Reg. Dist. No. 37

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs
Hospital, institution, or street address where death occurred:
Masonic Home of Md.
How long in hospital or institution? 9 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Baltimore Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4211 Edson Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Cora Emily Jones

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Carlisle R. Jones
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 13 - 1870

8. AGE: Years	Months	Days	If less than one day
75	8	16	..... hrs. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Peter D. Della
13. Birthplace Baltimore Md

MOTHER
14. Maiden name Emily A. Ross
15. Birthplace Somerset County

16. Informant Cora E. Schroeder
Address Masonic Home, Catonsville

17. Burial Date thereof Sept. 30-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt. Olivet
Location Baltimore Md
16. Funeral director Geo. L. Byfield Jr.
Address 1512 Hollins St

19 Sept 30 19 45 L. M. Schroeder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 19 45 at 10⁵ P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 19 45 to Sept. 29 19 45 and that I last saw her alive on Sept 29 19 45

Immediate cause of death	DURATION
Cardiac Decompensation	4 days
Due to Valvular Heart Disease	2 yrs.
Due to Arteriosclerosis	4 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. Solomon Sherman
M. D. or other
Address 2424 Eutaw Place Date signed 9/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 18814

1. PLACE OF DEATH:

County Baltimore

City or town Woodbrook (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Mos.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Baltimore

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 3107 Guilford Ave

(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Elizabeth S Kalb

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife William

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 30 1866

8. AGE: Years	Months	Days	If less than one day
79	2	18	..... hrs. ..... min.

9. Birthplace Mexico (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name George H Seymour

13. Birthplace Baltimore Md

MOTHER 14. Maiden name Sophine Gonzales

15. Birthplace Mexico

16. Informant Edgar S Kalb

Address 612 W Joppa Rd Towson Md

17. Burial, cremation, or removal (Which?) Burial Date thereof 9/21/45 (month) (day) (year)

Cemetery or crematory Woodlawn

Location Woodlawn Md

18. Funeral director Wilhelm Bros & Lee

Address 124 E Lexington St

19. 9-19 1945 Orig. Medical (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1945 at 10:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 15 1945 to Sept 18 1945

and that I last saw her alive on Sept 18 1945

Immediate cause of death	DURATION
Hypostatic Pneumonia	4 Weeks
Due to Chronic Myocarditis	5 yrs
Due to Hypertension	5 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Sanford C Blake M. D. or other

Address 422 Med. Arts Bldg. Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-L)

CERTIFICATE OF DEATH

P 118815 47

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 188 days
Hospital, institution, or street address where death occurred:
Veterans Administration Facility
How long in hospital or institution? 188 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7149 Martell Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war WWII

3. (a) FULL NAME
JOHN EDWARD KELLER

3. (b) Social Security Number
?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife .....
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 24, 1923

8. AGE: Years	Months	Days	If less than one day
22	3	2	..... hrs. ..... min.

9. Birthplace Pittsburgh, Pennsylvania
(Town, county, and state)
10. Usual occupation Clerk
11. Industry or business
FATHER 12. Name John Keller
13. Birthplace Poland
MOTHER 14. Maiden name Josephine Balukin
15. Birthplace Pennsylvania
16. Informant Clinical Records, Veterans Administration
Address Fort Howard, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 1 1945 (month) (day) (year)
Cemetery or crematory Sacred Heart of Mary
Location Burial
18. Funeral director Ullrich Funeral Home
Address 2108 Aliceanna St
19. 9-28 45 Archbald (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26 1945 at 2:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23 1945 to Sept. 26 1945 and that I last saw h. im alive on September 26 1945

Immediate cause of death	DURATION
CHONDRO-SARCOMA, RIGHT HIP	8 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Same as above
Date of op. 5/26/45
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE A. M. Balter
A. M. BALTER, LT. COL. CLINICAL DIRECTOR
Address Fort Howard, Md. Date signed 9/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DUPLICATE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

11881C

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 5 mos., 8 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 5 mos., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 122 S. Monroe St., Balto., Md.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Mary L. Kelly

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Joseph Kelly

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): October 3, 1896

8. AGE: Years	Months	Days	If less than one day
48	11	14	..... hrs. ..... min.

9. Birthplace: Greencastle, Pa. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Columbus Pentz

13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Marion Conrad

15. Birthplace: Pennsylvania

16. Informant: Mrs. Mary L. Kelly

Address: 122 S. Monroe St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 21, 1945 (month) (day) (year)

Cemetery or crematory: New Cathedral Cemetery

Location: 4300 Old Frederick Rd., Balto., Md.

18. Funeral director: Thomas J. Kenny

Address: Gilmor & Hollins St., Balto., Md.

19. 9/17/ 1945 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 17, 1945, at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9, 1945 to Sept. 17, 1945 and that I last saw her alive on September 17, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 Mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation Date of op.:

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Stewart L. Shaffer M.D. M.D. or other

Address: Mount Wilson, Maryland Date signed: 9/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 37 — 8807

1. PLACE OF DEATH:

County: Baltimore

City or town: Cockeysville (Rural)
(If outside city or town limits write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Cockeysville (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Padonia Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Lavina King

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: Joshua King

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June ? - ?

8. AGE: Years	Months	Days	If less than one day
? 95	?	?	..... hrs. ..... min.

9. Birthplace: Balto. Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Wm. H. Cannady

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Sara H. Selipp

15. Birthplace: England

16. Informant: H. H. Cannady

Address: Cockeysville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 28 1945 (month) (day) (year)

Cemetery or crematory: Poplar Grove Church

Location: Cockeysville, Md.

18. Funeral director: Landon M. Bowles

Address: Sparks, Maryland

19. Sept. 26 1945 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 25 1945, at 9:16 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1945, to Septem 25 1945 and that I last saw h.. alive on August 6 1945

Immediate cause of death	DURATION
Coronary occlusion	
Due to: Arteriosclerotic Heart Disease	
Due to: Fractured due to: Accidental falls, c.w.s.R.	
Other conditions: Unremitted fracture Left Humerus	June 20 1945

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of June 20, 1945

Where did injury occur? Padonia Road, nr. Texas (City or town) Maryland (County) (State)

Injured at home, farm, industry, public place (where?): At home

Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: Elizabeth B. Hamill, M.D.
M. D. or other

Address: Cockeysville, Md. Date signed: 9-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

08808

1. PLACE OF DEATH (83-a)

County Baltimore Registration Dist. No. 42

Village or City Halethorpe No. 1805 Paul Ave. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Ida E. Long

(a) Residence: No. 1805 Paul Ave. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F.	W	W.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas O. Long

6. DATE OF BIRTH (month, day, and year): Nov. 6, 1867

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	77	11	17	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: —

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: —

10. Date deceased last worked at this occupation (month and year) ____ 11. Total time (years) spent in this occupation ____

12. BIRTHPLACE (city or town) Maryland. (State or country)

FATHER

13. NAME Wm. Brent

14. BIRTHPLACE (city or town) Md. (State or country)

MOTHER

15. MAIDEN NAME Rosa Gloyd

16. BIRTHPLACE (city or town) Md. (State or country)

17. INFORMANT Family (Address) Halethorpe

18. BURIAL, CREMATION, OR REMOVAL Place Pasadena Md. Date 9/26, 1945

19. UNDERTAKER L. G. Cooley (Address) 150 E. Fountain

20. FILED Sept. 25, 1945 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Sept. (Month) 23 (Day), 1945 (Year)

22. I HEREBY CERTIFY That I attended deceased from Sept. 16, 1945, to Sept. 23, 1945.

I last saw h[er] alive on Sept. 17, 1945; death is said to have occurred on the date stated above, at 8:45 a.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	Sept 11-45
Other Contributory Causes of Importance:	
Arterio Sclerosis	

Name of operation ____ Date of ____

What test confirmed diagnosis? Death Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of injury ____, 19____

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify ____

(Signed) W. B. Larson M. D.

(Address) Halethorpe Md.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0889

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Howard
City or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
Street No. Mill St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Wilbur Kinsey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed or divorced
M	W	married

6.(b) Name of husband or wife Lillie Kinsey
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1867

8. AGE: Years 77 | Months 9 | Days 28 | If less than one day ..... hrs. ..... min.

9. Birthplace Ellicott City Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Isaiah Kinsey
13. Birthplace Md

MOTHER
14. Maiden name Mary Lawrence
15. Birthplace Md

16. Informant Lillie Kinsey
Address 903 Harlem ave Catonsville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-4-45 (month) (day) (year)

Cemetery or crematory St Johns
Location Ellicott City Md

18. Funeral director F.C. Weigenbottom
Address Ellicott City Md

19. 9/7 19 45 (Date rec'd by registrar) W.C. Andrews Deputy County Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 19 45 at 1 45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 19 45 to 9/1 19 45 and that I last saw h.. alive on 9/1/45 19

Immediate cause of death	DURATION
Arteriosclerotic Cardio-Vascular Disease	1 year
Due to -	
Due to -	
Other conditions none	

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George E. Burgtorf MD M. D. or other
Address Ellicott City Md Date signed 9/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40-)

CERTIFICATE OF DEATH

6:8810

Reg. Diat. No. 4-3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Overlea
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:
11 E. Overlea Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Overlea
(If outside city or town limits, write RURAL and give nearest town)

Street No. 11 E. Overlea Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

HARRY W. KIRSCH

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Agnes S. Kirsch

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 10th, 1877

8. AGE:	Years	Months	Days	If less than one day
	68	2	10	..... hrs. ..... min.

9. Birthplace: Balto., Md.
(Town, county, and state)

10. Usual occupation: Clerical

11. Industry or business: Baltimore City

FATHER
12. Name: Louis Kirsch
13. Birthplace: Balto., Md.

MOTHER
14. Maiden name: Mary L. Schulte
15. Birthplace: Balto., Md.

16. Informant: Mrs. H. W. Kirsch,
Address: 11 E. Overlea Ave.

17. burial
(Burial, cremation, or removal. Which?)
Date thereof: Sept. 24, 1945
(month) (day) (year)

Cemetery or crematory: Greenmount

Location: Balto., Md.

18. Funeral director: Kavanaugh Funeral Home
Address: 7401 Belair Road

19. Sept 22 19 45 Ino. J. L. Richardson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 20th, 19 45 at 12:10 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 20 19 45 to Sept 20 19 45
and that I last saw h[illegible] alive on Sept 19 19 45

Immediate cause of death	DURATION
Carcinoma of Stomach	1 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: [illegible]

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. S. Geary M. D. or other

Address: 6 [illegible] N Monroe Ave Date signed: 9/22/45


RECEIVED
SEP 26 1945
BUREAU F. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94G)

CERTIFICATE OF DEATH

18811 P

Reg. Dist. No. 31

1. PLACE OF DEATH:
County: Baltimore
City or town: Milford(Liberty Road)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 Yrs.
~~(If in hospital or institution, give~~ street address where death occurred:
3604 Croydon Road
How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Milford(Liberty Road)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3604 Croydon Road
(If rural, give LOCATION)
2.(a) If veteran, name war: --------

3.(a) FULL NAME: John Frederick Koenig

3.(b) Social Security Number: Fed. Employee

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: M. Katharine Koenig
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): August 17, 1888

8. AGE: Years	Months	Days	If less than one day
57	1	11	....hrs. ....min.

9. Birthplace: Baltimore City, Md. (Town, county, and state)
10. Usual occupation: Cashier
11. Industry or business: Dept. Internal Revenue
FATHER 12. Name: Martin Koenig, Sr
13. Birthplace: Baltimore, Md.
MOTHER 14. Maiden name: Amelia Stauch
15. Birthplace: Baltimore, Md.
16. Informant: M. Katharine Koenig (Wife)
Address: 3604 Croydon Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1 Oct. 1945 (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: Woodlawn, Md.
18. Funeral director: Walter Brooks Bradley
Address: 1922 W. North Avenue
19. 9-29 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 27 19 45, at 9:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 27 19 45, to Sept 27 1945 and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Angina Pectoris	24 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None. Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. D. Caples, M. D. M. D. or other
Address: Reisterstown, Md. Date signed: 9-28-'45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17-C)

CERTIFICATE OF DEATH

1-8812

★ Reg. Dist. No. 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County BALTIMORE

City or town DUNDALK (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: DUNDALK

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) LIFE

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MD. County BALTO.

City or town DUNDALK Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 1821 WEST AVE. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR NO

3. (a) FULL NAME MILTON C. KOHNE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 18 1929

8. AGE: Years	Months	Days	If less than one day
16	7	11	hrs. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual occupation LABORER

11. Industry or business WAREHOUSE

FATHER 12. Name CLIFFORD KOHNE

13. Birthplace BALTO. MD.

MOTHER 14. Maiden name AGNES WENKER

15. Birthplace BALTO. MD.

18. Informant CLIFFORD KOHNE (FATHER)

Address 1821 WEST AVE. DUNDALK MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof OCT. 2/45 (month) (day) (year)

Cemetery or crematory SACRED HEART

Location GERMAN HILL ROAD

18. Funeral director Lilly and Zeiler Inc.

Address 403 S. WOLFE ST.

19. 10/1 1945 (Date rec'd by registrar) Milton M. Knudsen Local Registrar Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 29 1945 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h____ alive on ____ 19____

	DURATION
Immediate cause of death: Fractured Skull	15 Mins
Due to: Fractured & Crushed Rib - Left Chest.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9-29-45.

Where did injury occur? FORT HOWARD - BALTO. - MD. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Place

Means of injury Auto Accident Injured at work? NO -

23. SIGNATURE M. D. Davis M.D. Asst. Supt. Med. Exam. - Balto. M.D. or Coor.

Address Dundalk - Md. Date signed 10-1-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

18813

Reg. Dist. No.

1. PLACE OF DEATH:

County: ~~Extension~~ Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years 2 mos. 23 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 4 yrs., 2 mos., 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No. 626 S. Bond St (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Boleslaw (Benny) Koszpura

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Koszpura

6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): 1884?

8. AGE: Years: 61? Months: Days: If less than one day: hrs. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: none

FATHER 12. Name: Unknown

13. Birthplace: "

MOTHER 14. Maiden name: "

15. Birthplace: "

16. Informant: Hospital records

Address: Catonsville, 28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 24 45 (month) (day) (year)

Cemetery or crematory: Holy Rosary

Location: Baltimore

18. Funeral director: Fred W. Ozaszewski

Address: 1950 Eastern Ave.

19. 9/21 19 45 A W Hedrick Clerk

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 20th 1945, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28 1941 to September 20/45 and that I last saw him alive on September 20 1945

	DURATION
Immediate cause of death: Coronary occlusion	3 ds.
Due to: Chronic arteriosclerotic cardiovascular disease	Indef.
Due to:	"
Other conditions: Diabetes mellitus	"

(Include pregnancy within 3 months of death)

Major findings of operations: Guillotine amputation lower third left leg - sclerotic occlusion ant. post. tibial art. Date of op. 5/6/45

Autopsy results: None held

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Henry C. Mead M.D.

Henry J. C. Mead, M. D. or other

Address: Catonsville, 28, Md. Date signed: 9/20/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Rec'd V. S.
9/21/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11)

18814

CERTIFICATE OF DEATH

★ Reg. Dist. No. 43

1. PLACE OF DEATH:
County Baltimore
City or town Overlea
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Overlea
(If outside city or town limits, write RURAL and give nearest town)
Street No. 10 E. Maple Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Josephine J. Kummelmann

3. (b) Social Security Number 212-16-4578

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	WIDOWED

6.(b) Name of husband or wife Herman Kummelmann
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7th. 1894

8. AGE: Years	Months	Days	If less than one day
51	0	29	hrs. min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual occupation At Home
11. Industry or business
FATHER 12. Name John A. Schmid
13. Birthplace Germany
MOTHER 14. Maiden name Theresa Gladden
15. Birthplace Germany
16. Informant Miss Theresa Kummelman
Address 10 E. Maple Ave. Overlea
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 8-1945 (month) (day) (year)
Cemetery or crematory Parkwood
Location Baltimore, Maryland
18. Funeral director
Address 7401 Belair Road
19. Sept. 7 1945 Mrs. C. L. Reifsnider Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~Sept. 5th~~ ~~Sept. 5, 1945~~ 19 45 at 1.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 2, 1945 to Sept. 5 1945 and that I last saw her alive on Sept. 4, 1945

Immediate cause of death	DURATION
Coronary thrombosis	1 d.
Due to	
Due to	
Other conditions Diabetes mellitus	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harold A. Gott M.D.
M. D. or other
Address 8100 Harford Rd. Date signed 9/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for the change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

File No. G 98 OCT 19 1945

8815

Reg. Diat. No. 40

1. PLACE OF DEATH:

County: Baltimore

City or town: Notch Cliff near Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Notch Cliff near Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Sister Mary Camille Leahy

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 10, 1897

8. AGE: Years	Months	Days	If less than one day
47 ~~48~~		16	hrs. min.

9. Birthplace: New York City (Town, county, and state)

10. Usual occupation: Teacher

11. Industry or business

FATHER — 12. Name: John Leahy

13. Birthplace: Ireland

MOTHER — 14. Maiden name: Lucie Colton

15. Birthplace: New York City

16. Informant: Sr. Mary Clara

Address: Notch Cliff, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 28 1945 (month) (day) (year)

Cemetery or crematory: Notch Cliff

Location: Glen Arm

18. Funeral director: Geo. M. Fenwick Son

Address: 84 W. Lexington

19. Sept 27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 26 1945, at 3.45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15 1945, to Sept. 26 1945, and that I last saw her alive on Sept. 19 1945

Immediate cause of death	DURATION
Myocardial decompensation	2
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

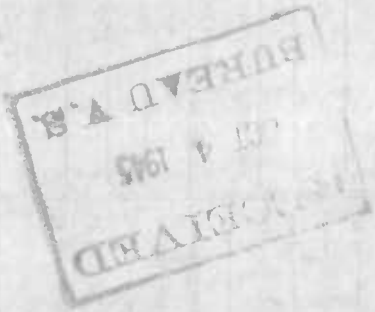
Address Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Allegheny
Jameson.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 225 Church Lane
(If rural, give LOCATION)
2.(a) If veteran, name war: W

3.(a) FULL NAME: Mary Tirza Lewin

3.(b) Social Security Number: [illegible]

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

B.(b) Name of husband or wife: Samuel
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 3, 1863

8. AGE: Years: 81 | Months: 9 | Days: 25 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Edward Watts
13. Birthplace: Md

MOTHER
14. Maiden name: Unknown
15. Birthplace: Md

16. Informant: Glenn Watts
Address: Pikesville Md

17. Burial, cremation, or removal. Which? Burial Date thereof: 10/1/45 (month) (day) (year)
Cemetery or crematory: Druid Ridge
Location: Pikesville Md
18. Funeral director: Wilson & Son Inc
Address: 1217 E Fond St

19. Rec'd 9-29 1945 E E Nichols Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 28 1945, at 8:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 9 1945 to Sept 28 1945 and that I last saw h[illegible] alive on Sept 28 1945

Immediate cause of death	DURATION
Chronic Myocarditis	years
Due to: Arteriosclerosis	years
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. E. Nichols M.D.
M. D. or other
Address: Pikesville 8 Md Date signed: 9-29-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

68817

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Balto
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
917 Wise Ave
How long in hospital or institution? 20 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Dundalk R.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 917 Wise Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lena M. Lipski

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 20, 1870

8. AGE: Years: 74 | Months: 11 | Days: 16 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

12. FATHER — Name: Joseph Milczarczyk
13. Birthplace: Poland

14. MOTHER — Maiden name: Katherine Lewandowski
15. Birthplace: Poland

16. Informant: Mrs Sam Hook
Address: 917 Wise Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 10, 1945 (month) (day) (year)
Cemetery or crematory: Sacred Heart of Mary
Location: German Hill Rd Md

18. Funeral director: D. J. Covington
Address: 21 N 25 St, Balto. 18, Md.

19. Sept 7 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 6 1945, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6 1945, to Sept 6 1945
and that I last saw ..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	Minutes
Due to	
Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. McCarmine M.D.
M. D. or other
Address: Dundalk Md Date signed 9/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

Reg. Dist. No. 32 — 8818

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Mt. Washington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Smith Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Mt. Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Smith Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ida H. Lochte

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Frank J. Lochte

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 22, 1869

8. AGE:

Years	Months	Days	If less than one day
76	4	17	hrs. min.

9. Birthplace: Baltimore County, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Oliver R. Ritter

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Julia Anne Keller

15. Birthplace: Maryland

16. Informant: Frank O. Lochte

Address: Smith Ave., Mt. Washington, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 - 12 - 45 (month) (day) (year)

Cemetery or crematory: St. Mary's

Location: Govans, Baltimore, Md.

18. Funeral director: H. J. Ruck

Address: 5305 Harford Road

19. 9 - 10 45 (Date rec'd by registrar) Dr. E. E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 9th, 19 45 at 9:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Usual hours, to Sept. 9, 19 45 and that I last saw her alive on Sept. 9, 19 45

Immediate cause of death	DURATION
Cerebral hemorrhage	4 hrs.
Due to Arterio Sclerosis	4 yrs
Due to Arterial hypertension	4 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. E. Nichols M.D. M. D. or other

Address: Pikesville-8, Md. Date signed 9/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(8819) P

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correctly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Baltimore Co
City or town: Bird River Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1615 Eareckson Place
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I ✓

3.(a) FULL NAME (LOHMEYER) Charles F. Lohmeyer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Caroline L. Lohmeyer
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): 2/19/1894

8. AGE: Years	Months	Days	If less than one day
51			...hrs. ...min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: Sheet Metal Worker
11. Industry or business
12. FATHER — Name: Wm C. L. Lohmeyer
13. FATHER — Birthplace: Germany
14. MOTHER — Maiden name: Louise Buddenbohn
15. MOTHER — Birthplace: Germany
16. Informant: Caroline L. Lohmeyer
Address: 1615 Eareckson Place
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 6 (month) (day) (year)
Cemetery or crematory: Parkwood Cem
Location: Rural
18. Funeral director: Ulrich Funeral Home
Address: 2004 E. Oriole St
19. 9-5 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 3, 1945, at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13, 1945 to Sept. 3, 1945 and that I last saw him alive on August 10, 1945

Immediate cause of death	DURATION
Gastric Hemorrhage	4 hours
Due to: Carcinoma of pancreas with extension to stomach & liver	1 year
Due to:	
Other conditions: Arteriosclerosis + anaemia, jaundice	

(Include pregnancy within 3 months of death)

Major findings of operation: ...Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ...Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ...Injured at work?

23. SIGNATURE: Maurice E. Shamer, M.D. (M. D. or other)
Address: 3300 N. Charles Street ...Date signed: 9/4/1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 6882 50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 9 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 1 month 9 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Havre de Grace

(If ontside city or town limits, write RURAL and give nearest town)

Street No. 313 North Union Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Amelia Ludwig

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B.(b) Name of husband or wife: Charles Ludwig, (d 1921)

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 9, 1871

8. AGE:

Years	Months	Days	If less than one day
74	1	6	..... hrs. ..... min.

9. Birthplace: Rumania (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER — 12. Name: Unknown

13. Birthplace:

MOTHER — 14. Maiden name: Unknown

15. Birthplace:

16. Informant: Hospital Records,

Address: Catonsville, 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/19/45 (month) (day) (year)

Cemetery or crematory: New Cathedral

Locafion: Frederick Rd

18. Funeral director: Edward Foulkrod

Address: 2359 Work Blvd

19. Sept 17 (Date rec'd by registrar) 19 45 A W Hebeler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 15 19 45, at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 6 19 45, to Sept. 15 19 45

and that I last saw her alive on September 15 19 45

Immediate cause of death: Terminal pneumonia — DURATION: 48 hrs

Due to: Acute myocardial insufficiency — 1 wk

Due to: Chronic hypertensive cardio-vascular disease — Indef

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Henry C. A. Mead, M.D.

M. D. or other

Address: Catonsville, 28, Md. Date signed: 9/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-L)

CERTIFICATE OF DEATH

08821 P 38

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 505 Wilton Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 6019 Bellona Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: SARAH EDEL McAFEE

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Clarence Talbot McAfee

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 22, 1868

8. AGE: Years	Months	Days	If less than one day
77	6	25	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Samuel Edel

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Eliza Cox

15. Birthplace: Maryland

16. Informant: Mrs. Walter J. Ehman

Address: 505 Wilton Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/20/45 (month) (day) (year)

Cemetery or crematory: Greenmount Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Baltimore, Md.

19. 9-19 '45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 17, 1945 at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11 1943, to Sept 7 1945

and that I last saw h alive on Sept 7 1945

	DURATION
Immediate cause of death: Coronary Thrombosis	Sudden
Due to: Coronary Arteriosclerosis	?
Due to: Generalized Arteriosclerosis	?
Other conditions: Chronic Myocarditis	?

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 3403 Fairview Blvd Date signed: 9/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and forcibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

1-882244 P

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Balto. Co.
City or town Essex
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 214 Humberg Ave.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Essex Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 214 Humberg Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME August C. McCormick

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 1897

8. AGE:

Years	Months	Days	If less than one day
48	3	22	hrs. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name August C. McCormick
13. Birthplace Balto. Md.

MOTHER
14. Maiden name Barbara C. Ball
15. Birthplace Balto. Md.

16. Informant Barbara C. Adams
Address 214 Humberg Ave.

17. Burial Date thereof Sept. 29/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18. Funeral director John A. Miller
Address 2334 Jefferson St.

19. 9 28 45 [illegible]
(Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26 19 45, at 8:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/26 19 45 to 9/26 19 45 and that I last saw him alive on 9/26 19 45.

Immediate cause of death Hemorrhage Apoplectic — DURATION 1 hour

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Knight T. Sadler M. D. or other
Address 5323 E. Baltimore St. Date signed 9/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08823

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville
(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months, 20 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 8 months, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(if outside city or town limits, write RURAL and give nearest town)

Street No. 844 West Fayette Street
(If rural, give LOCATION)

2.(a) If veteran, name war Spanish-American ✓

3.(a) FULL NAME Hugh McGuire

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	widowed

6.(b) Name of husband or wife ?

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 2, 1862

8. AGE: Years	Months	Days	If less than one day
83	7	24	..... hrs. ..... min.

9. Birthplace Ireland (Town, county, and state)

10. Usual occupation paddler

11. Industry or business peddling for self

FATHER
12. Name John McGuire
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Mary Mangan
15. Birthplace Ireland

16. Informant Hospital records
Address Catonsville, Balto.-28, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof 10-3-45 (month) (day) (year)

Cemetery or crematory Spring Grove State Hospital
Location Catonsville 28, Maryland

18. Funeral director Spring Grove State Hospital
Address Catonsville 28, Maryland

19. 10/3 1945 (Date rec'd by registrar) W. C. Rodriguez Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26, 1945, at 5:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6, 1945, to Sept. 26, 1945 and that I last saw h im alive on Sept. 26, 1945

	DURATION
Immediate cause of death: Chronic myocardial insufficiency	Indef.
Due to: Terminal pneumonia	15 hrs.
Due to:	
Other conditions:	

(Include pregnancy within 8 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert E. Gardner M.D.
Robert E. Gardner, M. D. M. D. or other

Address Baltimore - 28, Maryland Date signed 10/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15d)

CERTIFICATE OF DEATH

★ 08824 39

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County BALTIMORE COUNTY
City or town Glencoe - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Oldfield School, Glencoe, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Glencoe - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Alice Austen MC MURRAN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 30, 1861

8. AGE: Years	Months	Days	If less than one day
84	1	14	..... hrs. ..... min.

9. Birthplace Mississippi, U.S.A.
(Town, county, and state)
10. Usual occupation School Principal
11. Industry or business
FATHER 12. Name John T. McMurran
13. Birthplace Mississippi
MOTHER 14. Maiden name Alice Austen
15. Birthplace Baltimore, Md.
16. Informant Duncan McCulloch
Address Glencoe, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 16, 1945 (month) (day) (year)
Cemetery or crematory Emmanuel
Location Glencoe, Md
18. Funeral director Landon M. Brooks
Address Sparks, Md.
19. Sept. 15 1945 (Date rec'd by registrar) Anna Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1945, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 1945, to Sept. 1 1945
and that I last saw her alive on Sept. 14 1945

Immediate cause of death	DURATION
Cerebral thrombosis	
Due to Arteriosclerosis	
Due to Hypertension	
Other conditions Hypertensive heart disease	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George G. Merrill MD
M. D. or other
Address Baldwin, Md. Date signed 9/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

C8825 P

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Balto. Augsburg Home
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs
Hospital, institution, or street address where death occurred: Augsburg Home.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Campfield Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Herman Meyer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widower

6.(b) Name of husband or wife: Anna Meyer
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 8, 1865

8. AGE: Years	Months	Days	If less than one day
80	2	13	hrs. min.

9. Birthplace: Long Island N.Y.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER 12. Name: Carl Meyer
13. Birthplace: Germany

MOTHER 14. Maiden name: Strachelgahn
15. Birthplace: Germany.

16. Informant: Mt. Records Augsburg Home
Address: Campfield Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 24 45 (month) (day) (year)
Cemetery or crematory: St Pauls
Location: Violetville

18. Funeral director: L. Heemann & Son
Address: 32 S. Broadway

19. 9/24 19 45 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 21. 19 45, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15th. 19 45, to Sept. 21 19 45
and that I last saw h. alive on Sept. 20th. 19 45

Immediate cause of death: 1) - Coronary Sclerosis — Heart Disease — DURATION: 5 yrs.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Earl E. Chambers, M.D. (M. D. or other)
Address: 4105 Liberty Hts. Ln. Date signed: 9/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-C

08826 P

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Days

Hospital, Institution, or street address where death occurred:
Vets.Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: .....

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1700 Eutaw Place
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: GEORGE F. MILLER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Widowed

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 5-10-94

8. AGE: Years	Months	Days	If less than one day
51	4	14	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Butcher

11. Industry or business

FATHER — 12. Name: Henry Miller

13. Birthplace: Germany

MOTHER — 14. Maiden name: Sherman Miller

15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Fac.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 27, 1945 (month) (day) (year)

Cemetery or crematory: Louden Park Cemetery

Location: Baltimore, Md.

18. Funeral director: Oder Funeral Home Inc.

Address: 4644 York Rd., Balto., Md.

19. Sept. 25 (Date rec'd by registrar) 19 45 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 24, 1945, at 4:31 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 19, 1945, to September 24, 1945, and that I last saw him alive on September 24, 1945

Immediate cause of death	DURATION
Lymphoblastoma	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: A.M. Balter

A.M. BALTER, LT.COL., M.C. CHIEF DIR.

Address: Fort Howard, Md. Date signed: 9-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

08827

Reg. Dist. No. 30

P

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo. 2 wks. 3 days.

Hospital, Institution, or street address where death occurred:

Harlem Lodge

How long in hospital or institution? 1 mo. 2 wk. 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Meyer Mintz

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth data of deceased (mo., day, yr.): 1883

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
62				

9. Birthplace: Maryland. (Town, county, and state)

10. Usual occupation: Teacher

11. Industry or business

FATHER — 12. Name: A. J. Mintz

13. Birthplace: Poland

MOTHER — 14. Maiden name: Rebecca Cohen

15. Birthplace: Poland

16. Informant: Mr. Julius Mintz.

Address

17. Burial (Burial, cremation, or removal, which?) Date thereof 9-18-45 (month) (day) (year)

Cemetery or crematory: Bnai Israel

Location: Southern Ave

18. Funeral director: Jack Lewis Inc

Address: 1439 E. Baltimore St

19. 9/18 19 45 (Date rec'd by registrar) H. L. Hedrick D.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 17 1945 at 5 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 3 1945, to Sept. 16 1945 and that I last saw him alive on September 16 1945

Immediate cause of death	DURATION
CARDIAC FAILURE	7 days
Due to: Hypertensive cardio-vascular-renal disease	2 yrs.
Due to: Generalized arteriosclerosis	3 yrs.
Other conditions: PROSTATIC HYPERTROPHY	1 yr.
DEMENTIA PRAECOX	32 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arthur V. Mitchell and M.D. M. D. or other

Address: Harlem Lodge Catonsville, Md. Date signed: 9-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 896

CERTIFICATE OF DEATH

08828

★ Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Balto.

City or town: Gray Manor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Gray Manor

(If outside city or town limits, write RURAL and give nearest town)

Street No. 223 Parkwood Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: James Anthony Miesner

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 29 - 1945

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
	4	24		

9. Birthplace: Balto. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Morris Miesner

13. Birthplace: Canada

MOTHER — 14. Maiden name: Wanda Rymarzewski

15. Birthplace: Michigan

16. Informant: Mrs. Wanda Miesner

Address: 223 Parkwood Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 25-45 (month) (day) (year)

Cemetery or crematory: Fort Meade Md.

Location: Fort Meade Md.

18. Funeral director: John F. Connelly

Address: 414 Eastern Ave. Essex, Md.

19. Sept. 25 1945 John F. Connelly

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 22 1945 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 1945 to Sept 22 1945

and that I last saw him alive on Sept 22 1945

Immediate cause of death	DURATION
Fatal Sinus Thrombosis	6 hours
Due to: Otitis Media	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. A. Jacobs MD

M. D. or other

Address: 617 North Pl Date signed: 9/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (73-D)

05829

Registered No. 31

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2304 Birch Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore Co
(c) City or town Lansdowne (If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 Birch Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hugh Elliott Moore

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-8677

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Mrs Lucille Moore
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Feb. 22 1884

8. AGE: Years	Months	Days	If less than one day
61	6	16	hr. min.

9. Birthplace Little Rock, Arkansas (Town, county, and state)
10. Usual Occupation Travelling salesman
11. Industry or business Aluminum products

FATHER
12. Name Louis Moore
13. Birthplace Arkansas

MOTHER
14. Maiden Name Ida McPherson
15. Birthplace North Carolina

16 (a) Informant Mrs Lucille Moore
(b) Address 2304 Birch Drive

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/10/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) 9-10-45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1945, at 8 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1941, to Sept 8 1945 and that I last saw him alive on Sept 8 1945.

Immediate cause of death Chronic Myocardial Degeneration — Duration 4 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation no operation
Major findings of operation:

of autopsy: no autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joshua H Armacost M. D.
Address 6419 Windsor Mill Road Date signed Sept 8, 1945

VS/150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistieal tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08830

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
Veterans Administration Facility
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 604 N. Fulton Street
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: RANZEL R. PEED

3.(b) Social Security Number: 186031360

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sally Peed
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): July 9, 1897

8. AGE: Years	Months	Days	If less than one day
48	2		....hrs. ....min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Painter
11. Industry or business: ?

FATHER
12. Name: Lendon Peed
13. Birthplace: Virginia

MOTHER
14. Maiden name: Martha Bisfane
15. Birthplace: Virginia

16. Informant: Clinical Records, Veterans
Address: Administration, Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 12, 1945 (month) (day) (year)
Cemetery or crematory: Nashville National Cemetery
Location: Madison, Tenn.

18. Funeral director: A. Lee Oder
Address: 4644 York Road., Balto., Md.

19. Sept 11 1945 (Date rec'd by registrar) W. H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 9 1945, at 5:10a P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 4 1945, to Sept. 9 1945 and that I last saw him alive on September 9 1945

Immediate cause of death	DURATION
TUBERCULOSIS, CHRONIC, PULMONARY, FAR-ADVANCED	2 years
Due to:	
Due to:	
Other conditions: Luetic Heart Disease with aortic insufficiency	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Y. RICHARDS, MAJOR, M.C. Acting Chief, Medical Service
Address: Fort Howard, Md. Date signed: 9/10/45

MCD, Another Direct.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

08831

Reg. Dist. No. 34

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Balto.

City or town Fowblesburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Balto.

City or town Fowblesburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Addie Miller Pitts

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Wodowed

6.(b) Name of husband or wife Henry S. Pitts

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1868

8. AGE: Years	Months	Days	If less than one day
77	8	20	..... hrs. ..... min.

9. Birthplace Balto.Co.
(Town, county, and stste)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Miller
13. Birthplace Balto.Co.

MOTHER
14. Maiden name Margaret Benson
15. Birthplace Balto.Co.

16. Informant Benson Pitts
Address Upperco, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 25, 1945 (month) (day) (year)

Cemetery or crematory St. Paul's Lutheran

Location Balto.Co.

18. Funeral director J. F. Bline & Sons

Address Reisterstown, Md.

19. 9/24/ (Date rec'd by registrar) 1945 Cyril E. Franklin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/23/45 19..... at 4 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1/1/ 19 36 to 9/23/45 19.....

and that I last saw h C.r alive on 9/22/45 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Hypertension	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dewey L. Lahell M. D. or other

Address Reisterstown, Md. Date signed 9/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-H)

CERTIFICATE OF DEATH

Reg. Dist. No. 088241

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Balto.

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 2901 Dunglow Rd.

How long in hospital or institution? 20 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Dundalk.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2901 Dunglow Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Rose M. Prince

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	(Married)

6.(b) Name of husband or wife: Roy F. Prince.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 5 1899.

8. AGE: Years	Months	Days	If less than one day
46	3	7	..... hrs. ..... min.

9. Birthplace: Washington DC (Town, county, and state)

10. Usual occupation: Clerical,

11. Industry or business: Vets Bureau

FATHER

12. Name: Daniel M. Carthy.

13. Birthplace: D. C.

MOTHER

14. Maiden name: Mary Reilly.

15. Birthplace: Ireland.

16. Informant: Roy F. Prince.

Address: 2901 Dunglow Rd.

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) Sept (day) 15 (year) 45

Cemetery or crematory: Woodlawn Cem

Location: Balto.

18. Funeral director: Harry H. Welsh

Address: Holton & Glenmore Ave.

19. 9/14/45 19.. (Date rec'd by registrar) L. McCarmine Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 12 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 12 1945, to Sept 12 1945 and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Suffocation	Immediate
Due to: Gas poisoning (Illuminating)	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 9/12/45

Where did injury occur? Dundalk Balto. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) at home

Means of injury Gas. Injured at work? No

23. SIGNATURE: L. McCarmine M.D.

Deputy Med. Examiner

M. D. or other

Address: Dundalk Md. Date signed 9/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08833

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland
How long in hospital or institution? 23 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Q.A.
City or town: Baltimore - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. 229 Doris Ave., Brooklyn Hgts.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I ✓

3.(a) FULL NAME: HENRY J. RAESLER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna T. Raesler
6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): 10-6-1898

8. AGE:	Years	Months	Days	If less than one day
	46	11	13	...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Tallyman (Railroad)
11. Industry or business

FATHER
12. Name: August Raesler
13. Birthplace: ?

MOTHER
14. Maiden name: Anna ?
15. Birthplace: ?

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/24/45 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Md.

18. Funeral director: Wm. Cook
Address: St. Paul & Preston Sts.

19. 9-20 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19, 1945 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 27, 1945, to September 19, 1945 and that I last saw him alive on September 19, 1945

Immediate cause of death	DURATION
Tuberculosis, chr. pul. far. adv. active	Unknown
Due to	
Due to	
Other conditions: Malnutrition	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: A.M. Balter
A.M. BALTER, LT. COL., M.C. CLIN. DIR.
Address: Ft. Howard, Md. Date signed: 9-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P

08834

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: S. Rolling Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince George's

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5302 Emerson St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: AGNES EDITH RAILTON

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): March 10, 1879

8. AGE: Years	Months	Days	If less than one day
66	6	17	...hrs. ...min.

9. Birthplace: Kilmarnock, Scotland (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Robert Railton

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Bethiah Arthur

MOTHER — 15. Birthplace: Scotland

16. Informant: Mrs. Frederick Gittings

Address: Catonsville, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 9/29/45 (month) (day) (year)

Cemetery or crematory: Loudon Park Crematory

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 9-29-45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept/27, 1945, at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1945, to Sept. 27 1945

and that I last saw h.er alive on Sept. 26 1945

Immediate cause of death	DURATION
Carcinoma Transverse Colon	9 mo.
Due to	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Nelson K. Gallagher M.D. M. D. or other

Address: Catonsville 28, Md. Date signed 9-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

08835

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 96 days
Hospital, institution, or street address where death occurred:
Veterans Adm. Facility Ft. Howard, Md.
How long in hospital or institution? 96 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County .....
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4920 Curtis Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war WW-I ✓

3. (a) FULL NAME James Joseph RASKA

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife Divorced
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4/13/1900

8. AGE: Years	Months	Days	If less than one day
45	5		..... hrs. ..... min.

9. Birthplace Curtis Bay, Maryland (Town, county, and state)
10. Usual occupation U.S. Deputy Marshall
11. Industry or business

FATHER
12. Name James Raska
13. Birthplace Bohemia

MOTHER
14. Maiden name Mary Dvorak
15. Birthplace Bohemia

16. Informant Clinical Records, Vet. Adm. Fac.
Address Ft. Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/26/45 (month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Location Frederick Road

18. Funeral director Charles E. Schimunek
Address 2601-03 East Madison Street

19. 9/24/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 19 45 at 12:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19, 19 45 to Sept. 23 19 45 and that I last saw him alive on September 23, 19 45

Immediate cause of death	DURATION
Intrabdominal Hemorrhage	unknown
Due to Postoperative cholecystectomy	
Due to	
Other conditions Chronic glomerulonephritis with associated hypertension	unknown

(Include pregnancy within 3 months of death)

Major findings of operations Cholelithiasis
Date of op. Sept. 21, 1945
Autopsy results confirm the above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE A. M. BALTER, LT. COL., M. C. M. D. or other
Address Ft. Howard, Md. Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9th a)

CERTIFICATE OF DEATH

08836

★ Reg. Dist. No. 38

1. PLACE OF DEATH:
County Baltimore
City or town Parkville, Baltimore 14
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9302 Harford Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edward Scott Reese

3.(b) Social Security Number 217-07-3578

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife Laura C. Reese
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) April 20th 1896

8. AGE: Years	Months	Days	If less than one day
49	4	23	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Motion Picture Proj
11. Industry or business
FATHER 12. Name Winfield Reese
13. Birthplace Maryland
MOTHER 14. Maiden name Unknown
15. Birthplace Maryland
16. Informant Mrs Edward S. Reese
Address 9302 Harford Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/17/1945 (month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Location Baltimore, Maryland
18. Funeral director Lassahn Funeral Home
Address 7401 Belair Road
19. 9/15 19 45 A. M. Barow
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 19 45, at 11 30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....
and that I last saw h alive on ..... 19 .....

	DURATION
Immediate cause of death Heart disease, vascular coronary, & thrombosis	9/13/45
Due to Coronary disease with previous thrombosis	3 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Rollin C. Hudson MD
M. D. or other
Address Towson 4, Md Date signed 9/14/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

CERTIFICATE OF DEATH

Reg. Dist. No. 08837

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland
How long in hospital or institution? 17 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: 635 E. 37th St., Balto., Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: See above
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: PRESTON R. REYNOLDS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Minnie Reynolds
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): 11-27-89

8. AGE: Years	Months	Days	If less than one day
55	9	13	...hrs. ...min.

9. Birthplace: St. Michael's Md. (Town, county, and state)
10. Usual occupation: Mechanic
11. Industry or business
FATHER 12. Name: William Y. Reynolds
13. Birthplace: Deleware
MOTHER 14. Maiden name: Annie E. Wrightson
15. Birthplace: Daniel, Md.
16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Ft. Howard, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/14/45 (month) (day) (year)
Cemetery or crematory: Druid Ridge
Location: Pikesville Md
18. Funeral director: Wm. Cook Inc.
Address: St. Paul & Preston Sts. Balto., Md.
19. 9/13 19 45 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 10, 1945, at 1:45A. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 24, 1945, to September 10, 1945 and that I last saw h... im ...alive on September 10, 1945

Immediate cause of death	DURATION
Carcinoma of the Pancreas with metastasis	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: See above Date of op. 9-5-45
Autopsy results: Not done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. Y. Richards
H.Y. RICHARDS, MAJOR, M.C. ACT. CHIEF. DIR.
Address: Ft. Howard, Md. Date signed 9-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

08838

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Galatian Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Pikesville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 104 Sherwood Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Benjamin Franklin Rhodes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

8.(b) Name of husband or wife: Hannah Webb Rhodes

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 9, 1857

8. AGE: Years	Months	Days	If less than one day
88	-	25	..... hrs. ..... min.

9. Birthplace: Philadelphia, Pa. (Town, county, and state)

10. Usual occupation: Retired - Chemist

11. Industry or business

FATHER

12. Name: Charles Rhodes

13. Birthplace: Philadelphia, Pa.

MOTHER

14. Maiden name: Unknown

15. Birthplace: Philadelphia, Pa.

16. Informant: Mrs. George Buckman

Address: 104 Sherwood Ave., Pikesville

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 6, 1945 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Location: Woodlawn, Md.

18. Funeral director: E. Hillis Lamoreaux

Address: 4510 Liberty Heights Ave.

19. 9/5 19 45 (Date rec'd by registrar) W. P. Lindsay Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 4 19 45 at 3.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 19 45 to Sept 4 19 45

and that I last saw him alive on Sept 4 19 45

Immediate cause of death	DURATION
Coronary Occlusion	ante
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Jem A. Kuhlmann M. D. M. D. or other

Address: 3921 Edmondson Ave. Date signed: 9/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25-a)

CERTIFICATE OF DEATH

08839

Reg. Diat. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
323 Lenox Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 323 Lenox Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Annie Richardson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 15, 1872

8. AGE: Years: 73 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: ? Boardley
13. Birthplace: Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Md.

16. Informant: Mrs Rachel Scott
Address: 323 Lenox Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 29, '45 (month) (day) (year)
Cemetery or crematory: Pleasant Rest Cem.
Location: Baltimore, Co., Md.

18. Funeral director: Mrs Frances A. Hemsley
Address: 578 W. Biddle St.

19. 9/29/45 (Date rec'd by registrar) 18 ..... Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: September 26 1945 at 12:30 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1 19 45 to Sept 26 19 45
and that I last saw h alive on Sept. 25 19 45

Immediate cause of death	DURATION
Cardio-renal Disease	
Due to	2 yrs.
Due to	
Other conditions Varicosities of veins in legs.	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Louis A. Jolivan M.D. M. D. or other
Address: 2329 Gerard St. Date signed: Sept 26 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

08840 8

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 39 Wade Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3. (a) FULL NAME: Dennis J. Riordan

3. (b) Social Security Number: 10 NB

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife: Annie

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 19 1868

8. AGE: Years: 77 | Months: 7 | Days: 26 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER — 12. Name: Daniel J. Riordan

13. Birthplace: Ireland

MOTHER — 14. Maiden name: Katherine Costello

15. Birthplace: Ireland

16. Informant: Annie Riordan

Address: 39 Wade Ave Catonsville Md

17. Burial, cremation, or removal. Which?: Burial Date thereof (month) (day) (year): 9/8/45

Cemetery or crematory: New Cathedral

Location: Baltimore Md

18. Funeral director: Milhorn Look Inc

Address: 1210 E Fayette St

19. Sept 7 19 45 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 5 19 45 at 10 40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 12 19 40 to Sept. 5 19 45 and that I last saw h... alive on Sept 5 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	1½ hrs
Due to: Cardio-Vascular Renal Disease	5 yrs?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): .....

Means of injury ..... Injured at work?

23. SIGNATURE: George E. Moan M.D. M. D. or other

Address: 802 33rd Ave Date signed: 9-5-45

Catonsville Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08841

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson, 4 Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since Jan 28, 1945
Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson, Md.
How long in hospital or institution? Since Jan 28, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A A County
City or town: Green Haven
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1410 4th St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Lillian Elizabeth Robinson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Joseph W Robinson
6.(c) If alive, give age: 36 years
7. Birth date of deceased (mo., day, yr.): September 24, 1911

8. AGE: Years: 33 | Months: 11 | Days: 21 | If less than one day: ... hrs. ... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Frank Stones
13. Birthplace: Maryland
MOTHER 14. Maiden name: Mary Summerfield
15. Birthplace: Maryland
16. Informant: Personal History, Hospital Records
Address: Eudowood Sanatorium, Towson, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 24-45 (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: Woodlawn Md.
18. Funeral director: John C. Miller Inc.
Address: 2405 E. Oliver St.
19. 9-27-45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 27 1945, at 6:58 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 28 1945, to Sept 27 1945
and that I last saw h... alive on Sept 20 1945

	DURATION
Immediate cause of death: Pulmonary tuberculosis	about 7 years
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: William A Bridges M. D. or other
Address: Towson, 4, Maryland Date signed ...

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1426)

CERTIFICATE OF DEATH

P

08842

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Baltimore
City or town .....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
812 Regester Ave. (Armacost Nursing Home)
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County .....
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. Blackstone Apts., Charles & 33rd.
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME AGNES GALLAGHER RUSSUM

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Thomas Houston Russum
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 30, 1862

8. AGE: Years	Months	Days	If less than one day
83	5	5	..... hrs. ..... min.

9. Birthplace Dayton, Ohio
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name James Gallagher
13. Birthplace Va.

MOTHER
14. Maiden name Unknown
15. Birthplace "

16. Informant Mrs. Thomas Houston Russum
Address Blackstone Apts., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/8/45 (month) (day) (year)
Cemetery or crematory Greensboro,
Location Greensboro, Md.

18. Funeral director WM. J. TICKNER & SONS
Address Baltimore, Md.

19. 9/8 45 (Date received by registrar) A. W. Redmile Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5, 19 45 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/14/44 19 44 to 9/5 19 45
and that I last saw h[illegible] alive on Sept 4 19 45

Immediate cause of death	DURATION
Senility	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Charles R. Goodson M. D. or other
Address 3923 St. Paul St. Date signed 9/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

118844 P

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9503 Harford Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Alexander James Sinclair

3.(b) Social Security Number: 216-01-9361

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Osa Saluda
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 27 1879

8. AGE: Years	Months	Days	If less than one day
66			hrs. min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business
FATHER 12. Name: Geo T. Sinclair
13. Birthplace: Md
MOTHER 14. Maiden name: Rowena ?
15. Birthplace: Md.
16. Informant: Mrs Osa S. Sinclair
Address: 9503 Harford Rd
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9-30-45 (month) (day) (year)
Cemetery or crematory: Southern Meth. Cem.
Location: Timonium Md.
18. Funeral director: Leonard Buck
Address: 3305 Harford Rd
19. 9-29 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 28 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 20 1945, to Sept 27 1945
and that I last saw him alive on Sept 27 1945

Immediate cause of death	DURATION
auricular fibrillation	
Due to: age and arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Eldred Roberts MD (M. D. or other)
Address: Woodmont Rd Baltimore 12 Date signed: 9-29-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

08845

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:

County Baltimore

City or town Overlea

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred: 109 Chesley Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 Chesley ave. Overlea

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles O. Smick

3. (b) Social Security Number 212-05-6331

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife Lucy V. Smick

6.(c) If alive, give age ...... years

7. Birth date of deceased (mo., day, yr.) Aug. 4th 1876

8. AGE:

Years	Months	Days	If less than one day
69	1	12	...... hrs. ...... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual occupation Chauffeur

11. Industry or business Gas & Elec. Co.

FATHER

12. Name William O. Smick

13. Birthplace Baltimore, Maryland

MOTHER

14. Maiden name Frances Fendrich

15. Birthplace Baltimore, Maryland

16. Informant Mrs. Chas. O. Smick

Address 109 Chesley ave. Overlea

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 20th 1945 (month) (day) (year)

Cemetery or crematory Baltimore Cemetery

Location Baltimore, Maryland

18. Funeral director Lassahn Funeral Home

Address 7401 Belair Road

19. Sept. 19 1945 (Date rec'd by registrar) Mrs. A. Reifsnider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16th 1945, at 8 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 5 44 19.., to Sept 17 1945 and that I last saw h.. alive on Sept 16 45 19..

Immediate cause of death	DURATION
Hypertension	1 y.
Due to Cardiovascular [illegible]	
Due to Coronary Sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ...... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ...... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ...... Injured at work?

23. SIGNATURE Fred Ruzicka M. D. or other

Address [illegible] Date signed 9-17-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08846

Reg. Dist. No. 44

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 Days

Hospital, Institution, or street address where death occurred:

Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 18 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Edgewood

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Edgewood, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: GEORGE SMITH

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 2-19-1889

8. AGE:	Years	Months	Days	If less than one day
	56	7	0	..... hrs. ..... min.

9. Birthplace: Scranton, Pa. (Town, county, and state)

10. Usual occupation: Chauffer

11. Industry or business

FATHER — 12. Name: James Smith

13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Lula Smith

15. Birthplace: Pennsylvania

16. Informant: Clinical Records, Vets. Adm. Fac.

Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-22-45 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Md.

18. Funeral director: A. Lee Oder

Address: 4644 York Road., Balto., Md.

19. 9/22 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-19-45 19..... at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1, 1945, to September 19, 1945 and that I last saw him alive on September 19, 1945

Immediate cause of death	DURATION
Tuberculosis, chr. Pul., Far. Adv. Active	1 Yr. Plus
Due to	
Due to	
Other conditions: Tuberculosis Laryngitis	2 Mos. Plus
Tuberculosis Glossitis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? N/A

23. SIGNATURE: A.M. Balter

A.M. BALTER, LT. COL., M.C. CLIN. DIR.

Address: Ft. Howard, Maryland Date signed: 9-20-45

Rec'd VS
9/22/75

08847

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 30

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore Md

City or town 8 Roberts ave Catonsville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore

City or town 8 Roberts ave Catonsville Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Helen Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	married

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 14 1907

8. AGE:	Years	Months	Days	If less than one day
	39			..... hrs. ..... min.

9. Birthplace Ellicott City Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Frank Wallace

13. Birthplace Md

MOTHER 14. Maiden name Catherine Dorsey

15. Birthplace Md

16. Informant Ulysses G Smith

Address 8 Roberts ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 28 - 45 (month) (day) (year)

Cemetery or crematory Western Star

Location Baltimore Co. Md.

18. Funeral director John Frances A Hemsley

Address 578 W Biddle St.

19. 9/26 19 45 (Date rec'd by registrar) H. C. Bridges Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24th 1945 at 11.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 18 - 1944 to Sept 24 1945 and that I last saw her alive on 9-24-45 19.....

Immediate cause of death	DURATION
Carcinoma of left Breast	1 yr 9 mo 6 days
Due to	
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. F. Maloney M.D. M. D. or other

Address Catonsville, Md Date signed 9/25/45

P 6848

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Parkville, Maryland
(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Parkville
(If outside city or town limits, write RURAL and giva nearest town)

Street No. 2705 Maple Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Robert E. Stromberger

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

B.(b) Name of husband or wife: Albertina

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 23, 1863

8. AGE: Years	Months	Days	If less than one day
82	0	20	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Stationary Engineer

11. Industry or business: Retired

FATHER
12. Name: George Stromberger
13. Birthplace: Germany

MOTHER
14. Maiden name: Margaret (?)
15. Birthplace: Germany

16. Informant: Mrs. John F. Brown

Address: 2705 Maple Avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 15, 1945 (month) (day) (year)

Cemetery or crematory: Greenmount

Location: Baltimore, Maryland

18. Funeral director: William Cook, Inc.,

Address: 1217 St. Paul Street

19. 9-14 19..... E J [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 13 19 45, at 7.50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 15 19 45 to Sept. 13 19 45 and that I last saw him alive on Sept. 11, 19 45

Immediate cause of death	DURATION
Arteriosclerotic	2
Due to Cardio-vascular disease.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE: H. A. Groth, M. D.
M. D. or other

Address: 8100 Harford Rd Date signed 9/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

08849

(131-a)

1. PLACE OF DEATH

County Baltimore — Registration Dist. No. 42

Village or City Rosedale — No. Dalton Ave & Philadelphia Rd — Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Elizebeth G. Svoboda (LIBERTY)

(a) Residence: No. Dalton Ave & Philadelphia Road Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Married

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of: Rudolph Svoboda

6. DATE OF BIRTH (month, day, and year): Dec 12, 1894

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	50	9	13	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.:

10. Date deceased last worked at this occupation (month and year):

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Baltimore

FATHER

13. NAME: Jerome Vacek

14. BIRTHPLACE (city or town) (State or country): Bohemia

MOTHER

15. MAIDEN NAME: Anna Rich

16. BIRTHPLACE (city or town) (State or country): Bohemia

17. INFORMANT (Address): Rudolph Svoboda, Rosedale Md

18. BURIAL, CREMATION, OR REMOVAL — Place: HOLY REDEEMER Date: 9-29-1945

19. UNDERTAKER: Frank Brockson (Address): 900 Chestnut

20. FILED: 9/27/1945 — Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH: Sept. 25, 1945 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Sept 23, 1945, to Sept 25, 1945

I last saw her alive on Sept 25, 1945; death is said to have occurred on the date stated above, at 11:27 AM

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral Haemorrhage	6 hrs
due to Hypertension C-V	3 yrs
Disease, due to Chronic	
nephritis	3 yrs

Other Contributory Causes of importance:

Name of operation: none — Date of:

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of injury ____, 19____

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) W. H. Fuller M. D.

(Address) Ridge Rd. Baltimore 6 Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, **not** the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-3)

CERTIFICATE OF DEATH

10885 38

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Towson R.D. Raynmark
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? unknown

Hospital, institution, or street address where death occurred:
Satyr Hill Rd. nr. Baynesville

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Towson
(If outside city or town limits, write RURAL and give nearest town)

Street No. Satyr Hill Rd. nr. Baynesville
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Mary Tagg

3.(b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife Willian S. Tagg

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 1st, 1864

8. AGE: Years	Months	Days	If less than one day
81	5	5	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business .....

FATHER
12. Name William Boblitz
13. Birthplace unknown

MOTHER
14. Maiden name Dailey
15. Birthplace unknown

16. Informant Mr. Samuel Tagg

Address Towson R. F. D. 6, Md.

17. burial Date thereof Sept. 8, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parkwood

Location Baltimore, Md.

18. Funeral director Lassahn Funeral Home

Address 7401 Belair Rd.

19. Sept 7 1945 D. M. Bacon
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 1945, at 8⁴⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 11, 1936, to Sept. 6, 1945
and that I last saw h.. alive on Sept. 5, 1945.

	DURATION
Immediate cause of death Cerebral Hemorrhage right, with Left Hemiplegia	8/9/45
Due to Hypertension	8 yrs.
Due to Arteriosclerosis (with Senile changes)	Unk.
Other conditions Bronchitis, chronic	10 yrs. +

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Rollin E. Hudson M.D.
M. D. or other

Address Towson, Md. Date signed 9/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

(18851 P)

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Balto

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 813 Braeside Rd

How long in hospital or institution? Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 813 Braeside Rd

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: George Arlton Tatum

3. (b) Social Security Number: 214-01-1474

4. Sex	5. Color or race	7.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Anne May

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): 11-25-1881

8. AGE: Years: 63 | Months: 9 | Days: 8 | If less than one day: ... hrs. ... min.

9. Birthplace: Balto Md (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Clothing

FATHER — 12. Name: James Tatum

FATHER — 13. Birthplace: Balto Md

MOTHER — 14. Maiden name: Mary J Shot

MOTHER — 15. Birthplace: Balto Md

16. Informant: Mrs Anne M Tatum

Address: 813 Braeside Rd

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 9-4-45 (month) (day) (year)

Cemetery or crematory: WOODLAWN

Location: WOODLAWN, MD.

18. Funeral director: G. LESTER WEBER

Address: 2503 EDMONDSON AVE.

19. Sept 3 1945 (Date rec'd by registrar) A. W. Hedrick Registrar

A.E.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 2 1945 at 3 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Coronary occlusion	
Due to:	
Due to: sudden death	
Other conditions: Pregnancy	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Geo M Kieffer Jr Asst Med Exam Balto Co M. D. or other

Address: 1010 Leadenhall Date signed 9-3-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

08852 P

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 years
Hospital, institution, or street address where death occurred: Bologna Ave, Lutherville
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: (If outside city or towo limits, write RURAL and give nearest town)
Street No. Bologna Ave - Lutherville (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John T. Taylor

3.(b) Social Security Number: 217-03-3366

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Addie Taylor
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 4th - 1875

8. AGE: Years	Months	Days	If less than one day
70	5	9	hrs. min.

9. Birthplace: Cockeysville Md (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name:
13. Birthplace: Cockeysville, Md
MOTHER 14. Maiden name: Salah ?
15. Birthplace: Cockeysville, Md
16. Informant: Mrs Addie Taylor
Address: Bologna Ave, Lutherville
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-12-1945 (month) (day) (year)
Cemetery or crematory: Pleasant Rest
Location: Towson, Baltimore, Co.,
18. Funeral director: Mrs Geo H. Holland
Address: 1621 Druid Hill Ave, Balto, Md
19. 9/11 19 45 D. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 9 19 45, at 9:25 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 19 45 to Sept 8 19 45
and that I last saw him alive on Sept 7 19 45

Immediate cause of death	DURATION
Pneumonia Bronchial in 24 hours.	9-6-45
Cerebral hemorrhage Duration	9-4-45
Due to: Hypertension	Unk
Due to: Arteriosclerosis	Unk
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Bennett A. Dean M. D. or other
Address: Lutherville, Md Date signed: 9/8/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08853

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Balto.

City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Balto.

City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 23 Stocksdale Ave
(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Emma C. Tillman

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Richard Tillman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1860

8. AGE: Years	Months	Days	If less than one day
84	9	7	..... hrs. ..... min.

9. Birthplace Sweden
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Johansen Johnson
13. Birthplace Sweden

MOTHER
14. Maiden name Johanna Benhenson
15. Birthplace Sweden

16. Informant Mrs. Raymond Whitcomb

Address Owings Mills, Md.

17. Burial Date thereof Sept. 8, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Druid Ridge

Location Balto. Co.

18. Funeral director J. F. Eline & Sons

Address Reisterstown, Md.

19. Sept. 8 1945 Mary B. Eline
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1945, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-30 1938 to 9-5 1945 and that I last saw h~~er~~ alive on 9-5 1945

Immediate cause of death	DURATION
Arteriosclerosis	5 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None. Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. D. Eagles, M. D.
M. D. or other

Address Reisterstown, Maryland Date signed 9-8-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

18854

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Glyndon
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
322 Central Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1828 Bolton St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Andrew H. Troeger

3.(b) Social Security Number: 215-05-9832

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Martha M. Troeger

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 5, 1885

8. AGE: Years	Months	Days	If less than one day
60	6	21	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Safe Deposit & Transit Co.

FATHER
12. Name: Andrew Troeger
13. Birthplace: Germany

MOTHER
14. Maiden name: Rose Wright
15. Birthplace: Balto., Md.

16. Informant: Mrs. Martha Troeger
Address: 1828 Bolton St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/29/45 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 9/29 1945 (Date rec'd by registrar) A. W. Hearick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 26 1945, at 10:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-15-45 to 9-26 1945
and that I last saw him alive on September 25 1945

Immediate cause of death	DURATION
Myeloid Leukemia (Clin.)	3 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: D. D. Caples, M. D.
M. D. or other
Address: Reisterstown, Maryland Date signed: 9-26-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3d)

08855 P

CERTIFICATE OF DEATH

Reg. Diat. No. 32

1. PLACE OF DEATH:
County: Baltimore County
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, institution, or street address where death occurred:
1714 Reisterstown Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1714 Reisterstown Road
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: John E. Tucker

3.(b) Social Security Number: 217-05-8406

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah L. Tucker
6.(c) If alive, give age: 49 years
7. Birth date of deceased (mo., day, yr.): July 27, 1895

8. AGE: Years	Months	Days	If less than one day
50	1	23	...hrs. ...min.

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business: Retired

FATHER
12. Name: John Tucker
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary A Leech
15. Birthplace: Maryland

18. Informant: Sarah L. Tucker, Reisterstown, Md.
Address: 1714 Reisterstown Rd. Baltimore Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-22-45 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18. Funeral director: Thomas L. Schwab
Address: 2101 Frederick Ave. Balto. Md.

19. 9/20 19 45 A. W. Kriel Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19, 1945, at 10:40 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 9/17/45 19... to 9/19/45 19...
and that I last saw h...M... alive on 9/18/45 19...

Immediate cause of death	DURATION
Myocarditis	...
Fibrosis	...
Due to: Bronchial Asthma	...
Due to:	...
Other conditions	...

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: Jas. L. Schell, M. D. or other
Address: Reisterstown, Md. Date signed 9/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-2)

CERTIFICATE OF DEATH

08856

Reg. Dist. No.

P

Dr. D. D. Caples 6 Valley Rd.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Edmondson Ave Blvd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Bernard Henry Upman

3.(b) Social Security Number: 220-09-4928

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 5 1907

8. AGE: Years: 38 | Months: 7 | Days: 5 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Catonsville Md (Town, county, and state)

10. Usual occupation: Maryland Drydock (Timekeeper)

11. Industry or business

FATHER — 12. Name: Philip L. Upman

13. Birthplace: Md.

MOTHER — 14. Maiden name: Katherine E. McComas

15. Birthplace: Md

16. Informant: Mr. Philip L. Upman

Address: Edmondson Ave Blvd Catonsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-12-45 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Baltimore Md

18. Funeral director: Leonard J. Ruch

Address: 6305 Harford Rd

19. 9/11 19 45 A. W. Hedrick D.R. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 8 19 45 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-8 19 45 to 9-8 19 45

and that I last saw h..... alive on not seen alive 19.....

Immediate cause of death	DURATION
Cardio-Vascular Disease (Hypertension)	3 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None. Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: D. D. Caples, M. D. M. D. or other

Address: Reisterstown, Md Date signed: 9-10 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

118857 D

Reg. Dist. No. 41

1. PLACE OF DEATH:
County Balto Co
If not in hospital, give street address or location
City or town (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 4 Midway Inverness
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto. Co.
City or town (If outside city or town limits, write RURAL and give nearest town)
Street No. 2901 Dunglow Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Anna Agnes Vaughn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 16 1876

8. AGE: Years	Months	Days	If less than one day
69	1	15	..... hrs. ..... min.

9. Birthplace Penna (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Peter Brynes

13. Birthplace Penna

MOTHER 14. Maiden name Anna Blackwood

15. Birthplace Penna

16. Informant Mrs Brannigan

Address 2901 Dunglow Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 2, 1945 (month) (day) (year)

Cemetery or crematory New Cathedral Cem.

Location Edmondson Ave Balto Md.

18. Funeral director D. J. Cunningham

Address 21 N 25 St. Balto 18. Md.

19. 10-1 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29 1945, at 4:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 20 1944 to 9-29 1945 and that I last saw h...ca...alive on 9-29 1945

	DURATION
Immediate cause of death Myocardial failure	6 days
Due to Hypertension, Cardio-vascular renal Disease.	5 yrs.
Due to	
Other conditions SEE OTHER SIDE	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Eugene F. Neve M. D. or other

Address 7001 Morning View Ave Date signed 9-30-45
Dundalk, Md

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Patient was injured Sept 12 1945. [redacted] was treated at City Hospital for 1st-2nd degree burns of both arms and chest and lacerations of the scalp. admitted for observation same day of the injury
Discharged Sept 22, 1945.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

08858

Reg. Dist. No. 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Texas

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yr. 2 mo. 14 da

Hospital, institution, or street address where death occurred:

Baltimore County Home

How long in hospital or institution? 6 yr. 2 mo. 14 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Texas Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME John Vogel

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 6, 1860

8. AGE:

Years	Months	Days	If less than one day
85	6	21	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Farm Laborer

11. Industry or business

FATHER

12. Name: Wolf Vogel

13. Birthplace: Germany

MOTHER

14. Maiden name: Catherine Abtine

15. Birthplace: Germany

16. Informant: Baltimore Co., Home Register

Address: Texas, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 28 1945 (month) (day) (year)

Cemetery or crematory: St. John's Cemetery

Location: Elliott City, Md.

18. Funeral director: Lilly & Zeiler, Inc.

Address: 4038 E. Wolfe St.

19. 9/27 1945 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 27 1945, at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11 1939, to Sept 27 1945, and that I last saw h... alive on 9/26 1945.

Immediate cause of death	DURATION
Cerebral Thrombosis	1 mo.
Due to: Arteriosclerosis	
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Hilmer C. Enos M.D. (M. D. or other)

Address: Cockeysville Md. Date signed: 9/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (06a)

CERTIFICATE OF DEATH

(18859)

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Garrison
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Garrison
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Robert Edward Walker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1945

8. AGE: Years	Months	Days	If less than one day
0	2	24	hrs. min.

9. Birthplace Garrison, Md. (Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name Thomas Walker
13. Birthplace North Carolina

MOTHER
14. Maiden name Lucille Adkins
15. Birthplace Virginia

16. Informant Thomas Walker
Address Garrison, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 - 19 - 45 (month) (day) (year)
Cemetery or crematory St. Thomas
Location Garrison Forrest, Md.
18. Funeral director Frank H. Newell
Address Pikesville, Md.

19. 9 - 19 45 (Date rec'd by registrar) Dr. EE Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 - 1945, at 730A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 16 - 1945, to Sept 18 1945
and that I last saw h... alive on Sept 17 1945

	DURATION
Immediate cause of death Status Lymphaticus	per Lung
Due to Cold & Fever &	
Bronchitis	3 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. E. Nichols M.D. M. D. or other
Address Pikesville Md Date signed 9-18-45

Evidence for change of age is shown on FLM No. G98 SEP 19 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73rd)

CERTIFICATE OF DEATH

08860 8

30

Reg. Dist. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 9 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 1 month 9 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No.: Kirkleigh Heights, Roland Park

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Anna Marie Weddigan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Theo. G. [illegible] Weddigan

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 29, 1856

8. AGE: Years	Months	Days	If less than one day
89 ~~90~~	5	11	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER — 12. Name: Daniel Herberts

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Mary Kron

MOTHER — 15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Catonsville, 28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-12-45 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Hyglenick ave

18. Funeral director: Thos. J. Kenny

Address: Hollins & Gilmor

19. 9-10 19 45 [signature] Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 9 1945 at 3:20A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1st 1945 to Sept. 9 1945 and that I last saw her alive on September 9 1945

Immediate cause of death	DURATION
Uremia	3 days
Due to: Acute hemorrhagic nephritis	Indef
Due to: Chronic arteriosclerotic Cardiovascular Disease	W
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry C. A. Mead, M. D.

Henry C. A. Mead, M. D. M. D. or other

Address: Catonsville, 28, Md. Date signed 9/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-A)

CERTIFICATE OF DEATH

Reg. Diat. No. 18861 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, Institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Deale (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Perry A. Whittington

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elsie Knopp Whittington

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): 1945

8. AGE: Years	Months	Days	If less than one day
60	0	19	hrs. min.

9. Birthplace: Nutwell, A.A. County, Md. (Town, county, and state)

10. Usual occupation: Waterman

11. Industry or business

FATHER — 12. Name: George Frank Whittington

FATHER — 13. Birthplace: Nutwell, Md.

MOTHER — 14. Maiden name: Sarah Chaney

MOTHER — 15. Birthplace: Dunkirk Md.

18. Informant: Mrs. Elsie Whittington

Address: Deale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 25, 1945 (month) (day) (year)

Cemetery or crematory: Deale Cemetery

Location: Deale, Md.

18. Funeral director: J. E. Hambleton & Son

Address: Galesville, Md.

19. 9/23 1945 (Date rec'd by registrar) W. C. Gardner Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 22 1945, at 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__ to ____ 19__

and that I last saw h____ alive on ____ 19__

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to Cardio-Vascular Disease	
Other conditions Sudden death	
(Include pregnancy within 3 months of death) Pregnancy	

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work? ____

23. SIGNATURE: G. Franklin Hall M. D. or other

Address: 1010 Leeds Ave Date signed: 9-22-45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. [redacted]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore ~~City~~, Maryland
(b) Street address 5215 Kenwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Raspeburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5215 Kenwood Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Anna M. Windisch WINDISCH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or ~~wife~~ William H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9th 1920

8. AGE: Years	Months	Days	If less than one day
25	6	3	hr. min.

9. Birthplace Balto. Co. Maryland
(Town, county, and state)
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name William M. Bierman
13. Birthplace Balto. Co. Maryland

MOTHER
14. Maiden Name Lena Vogt
15. Birthplace Baltimore, Maryland

16 (a) Informant William H. Windisch
(b) Address 5215 Kenwood Ave. Balto. 6 Md.

17 (a) Burial (b) Date thereof 9/17/1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville, Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

19 (a) (b)
(Date received by local reg.) Registrar

SEP 14 1945
Huntington for Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1945, at 8:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wounds of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 12 1945 at 6:10 P.M.
(b) Where did injury occur? 5215 Kenwood Ave
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? no
(d) Means of injury Shot himself in chest

23. Signature Robert L. Fortune M.D.
Medical Examiner.
Date signed 9-13-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

P

08863

Reg. Dist. No. 38

1. PLACE OF DEATH: Balto,

County

City or town Ruxton, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No. Ruxton, Md

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Eugene Lewis Wolfe

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Margery Levering

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 20, 1892

8. AGE: Years	Months	Days	If less than one day
53	1	3	hrs. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual occupation Manufacture

11. Industry or business

FATHER 12. Name Francis E. S. Wolfe

13. Birthplace

MOTHER 14. Maiden name Mary J. Reaney

15. Birthplace

18. Informant Mr Edwin W. Levering Jr.

Address Ruxton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 26/45 (month) (day) (year)

Cemetery or crematory Druid Ridge

Location Pikesville, Md

18. Funeral director John O. Mitchell & Sons Inc

Address 1900 Eutaw Place,

19. 9/25 19 45 Registrar

(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23, 19 45, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6 19 26, to Sept 23 19 45, and that I last saw h... alive on Sept 22 19 45

Immediate cause of death	DURATION
Acute pulmonary edema	5 hours
Due to Arteriosclerotic Heart disease: symptoms	8 years
Due to Generalized arteriosclerosis — Coronary artery sclerosis — Symptoms	8 yrs
Other conditions Hypertension	13 years
Myocardial infarct (Include pregnancy within 3 months of death)	March '45

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Louis P. Hamburger M.D. M. D. or other

Address 1207 Eutaw Place Date signed Sept 25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10564

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 58 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland
How long in hospital or institution? 58 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5320 Dogwood Road., Woodlawn
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: JOSEPH YANKOVITZ

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Helen Yankovitz
6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): January 2, 1891

8. AGE: Years	Months	Days	If less than one day
54	8	2	....hrs. ....min.

9. Birthplace: Serbia
(Town, county, and state)
10. Usual occupation: Painter and Paper hanger
11. Industry or business:

FATHER
12. Name: Daman Yankovitz
13. Birthplace: Serbia

MOTHER
14. Maiden name: ?
15. Birthplace: Serbia

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 8, 1945 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: Wm. Cook
Address: St. Paul & Preston Sts.,

19. Sept 5 1945 (Date rec'd by registrar) Balto., Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 4, 1945, at 5:00A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8, 1945, to September 4, 1945 and that I last saw him alive on September 4, 1945

Immediate cause of death	DURATION
Pyelonephritis	Unknown
Due to: Ureteritis	
Due to: Cystitis	
Other conditions: Cirrhosis of liver	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Substantiated above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: A.M. Balter
A.M. BALTER, LT. COL., M.C., A.D.C. Hosp. DIR.
Address: Ft. Howard, Md. Date signed: 9-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15